Maternal and Child Health Services
Title V Block Grant

State Narrative for West Virginia

Application for 2011
Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications are located at the following address:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

While there has been established federal expectation that public forums be held around the Block Grant, West Virginia has found this to be an expensive and inefficient, less than effective means of having topical discussions about the use of Title V resources. To counter this, OMCFH has involved critical stakeholders in all facets of charting a course for the use of multiple funding streams that support maternal, child and family health activities in our State. The use of stakeholder advisories, task forces to study particular population groups and issues, engagement with established non-Title V advisories where we have a seat at the table, and lastly public forums and specific engagement of parents using our parent-to-parent networks. The end result is that we don't have one isolated event to seek public input about the use of Office resources but rather have on-going study and action plan development, as evidenced by the following examples: The establishment of the WV Perinatal Partnership, which includes multiple personnel from the OMCFH and the involvement of the Office Director, has developed an action plan for

changes in the perinatal system. The details of the plan and the action steps are woven throughout the Block Grant and Needs Assessment materials but have included successful procurement of legislative resources and statutory changes necessary to expand metabolic screening to the 29 tests as recommended by the Secretary's Advisory Committee on Heritable Disorders and Genetic Diseases. In addition, because of Perinal Partnership recommendations, legislation passed that allows the State to establish the expectation that all medical practitioners serving pregnant women will use a risk screening instrument regardless of the woman's insurance carrier and that information will come into the OMCFH to be used for planning purposes and will affect direct patient care. Another example is the Birth to Three/Part C Early Intervention Program which has experienced such extremes in participation that the State had to make changes in our eligibility definitions in order to keep the system solvent. Parents of participants were involved in the decision making process. The Maternal Mortality Review Team was established in response to Perinatal Partnership recommendations which resulted in a Legislative mandate and has since reviewed cases from 2007 and 2008. The Maternal Mortality Review Team has made several recommendations to enhance care of the pregnant woman who presents to the ER. An action plan is being developed to explore educational options. Also during fiscal year 2010, public forums for Oral Health were held across the state and resulted in the development of a State Oral Health Plan.

Public forums have been historically held for parents and participants of CSHCN and Birth to Three services. These forums have resulted in multiple suggestions to improve services and as an example, the WVOMCFH plans to add SCID to newborn metabolic screening.

The Block Grant is posted on the WVOMCFH web site and elicits requests and responses.

A summary of the application and needs assessment will be completed and sent to all WVOMCFH stakeholders and partners for review and comments.

The above is provided as a confirmation of how public input and consensus building guides what we do and details of efforts are woven throughout this application. The attachment in this section includes a list of the WV OMCFH advisories and members.
An attachment is included in this section.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

Although West Virginia has many health care issues such as smoking among pregnant women, infants born prematurely, infants born with low birth weight, obesity and asthma, the WV OMCFH has woven together a patchwork of funding streams to create a system of care for women, infants, and children, including adolescents and those with special health care needs. The WV OMCFH has developed strong partnerships across the State with the medical community, private sector, as well as community health centers and local health departments, all in an effort to assure access. Medicaid has purchased services for their beneficiaries at the request of Title V but they, too, are facing financial woes.

The OMCFH, like MCH programs across the country, is in a constant struggle to meet the need/demand of maternal and child health populations with limited fiscal resources. Health care inflation has seriously reduced the purchasing power of resources available to this Office. As a consequence of the increased demand, the OMCFH has looked for every opportunity to seek non-traditional funding streams to support services for maternal and child health populations.

The West Virginia 2010 Five Year Needs Assessment indicates the following priorities in the MCH population groups:

A. Pregnant women, women of childbearing age, mothers and infants
1. Reduce the incidence of prematurity and low birth weight
2. Reduce the infant mortality rate
3. Decrease smoking among pregnant women

B. Children and Adolescents
1. Assure that children and families access health care financing and utilize services
2. Reduce smoking among adolescents
3. Reduce obesity in the State's population
4. Decrease the incidence of fatal accidents caused by drinking and driving
5. Increase the percentage of adolescents who wear seat belts
6. Reduce accidental deaths among youth 24 years of age or younger

C. Children with Special Health Care Needs
1. Maintain and/or increase the number of specialty providers in health shortage areas through recruitment
and credentialing.
2. Assure that children and families access health care financing and utilize service

III. State Overview

A. Overview

West Virginia is surrounded by Pennsylvania, Maryland, Virginia, Ohio, and Kentucky and is commonly referred to as a South Atlantic state. The Appalachian Mountains extend through the eastern portion of the state, giving West Virginia the highest elevation of any state east of the Mississippi River. The second most rural state in the nation, 20 of West Virginia's 55 counties are 100% rural according to the Census Bureau definition, with an additional 14 more than 75% rural. West Virginia is the only state that lies entirely in the Appalachian Region. Even so, West Virginia is located within 500 miles of 60% of the nation's population. The state is traversed by two north/south and one east/west interstates that connect its major population centers. In addition, I-68, which ends at Morgantown, where West Virginia University is located, provides access to Washington, D.C. and Baltimore, MD. Interstate 68 also connects with Interstate 79 providing access to Charleston, WV, our state capitol. Winding secondary roads connect the majority of the state's population, with little to no public transportation available between many of the small, isolated towns. Therein lies the single most often cited issue with access to health care for many of the state's residents.

As of January 2010, 36 of WV's 55 counties were classified as medically underserved areas with an additional 13 counties classified as partially underserved. Only six counties in the entire State were considered to have adequate medical manpower to meet the population need. The WV Board of Medicine, in 2009, reported that the current number of licensed physicians in WV is 5,705. Of this 5,705, some, while licensed, are not actively practicing. Ultimately, the number of practicing physicians across the entire state is 3,739. The Board of Medicine also reports that there are 553 physician assistants. West Virginia has one School of Osteopathic Medicine and historically their physicians have established practices in our state. The Board of Osteopathy reported in May 2009, 746 D.O.s were in active practice.

In 2002, The American College of Obstetricians and Gynecologists (ACOG) named West Virginia as one of nine "Red Alert" states with a looming crisis in the availability of obstetrical care, due to physicians' problems in finding or affording medical liability insurance in the state. Without liability insurance, OB/Gyns are forced to stop delivering babies, curtail surgical services, or close their doors--aggravating conditions in a state that already has many medically underserved areas. Information from ACOG surveys showed that without liability reform over half of all OB/Gyn residents planned to leave West Virginia as did a majority of private practice OB/Gyns. ACOG also reported problems in recruiting new OB/Gyns to the state. On March 19, 2003 ACOG applauded West Virginia lawmakers for their enactment of HB 2122, legislation to address the state's chronic medical liability insurance problems.

The WV Perinatal Partnership, which includes representatives from the OMCFH, has reported that the availability of OB/Gyns and other practitioners to provide prenatal care and delivery continues to be problematic. Not every county has sufficient births to justify labor and delivery at local hospitals, making it necessary for WV women to be served outside the boundaries of our state. The Board of Medicine, in 2009, reports that there are 159 M.D.s and another 23 D.O.s delivering infants across our state.

Community health centers have played a critical role in improving access to health care for all populations across WV. The community health center network is supported with state appropriations and there are multiple centers that receive both state and federal resources. Historically, community health center networks have received only $150,000 per year for bricks and mortar activities. In a recent meeting with Senator Jay Rockefeller, the Office was advised that the community health centers would be able to apply for resources under the American Recovery and Reinvestment Act that would allow them to expand their physical plants. We are working with the community health centers on this issue in hopes that the physical expansion of the facilities will allow them to recruit dental health practitioners. The lack of available oral health

services for adult persons in the state is a critical problem. Also, $1,000,000 was spent on oral health equipment for community health centers during the 2010 fiscal year. This equipment will be ready for use July 1, 2010.

The OMCFH has been a strong supporter of the evolving community health center network dating back to the early 1980's. The networks at that point were struggling, and beginning in the '80's to this date the Office has used the community health centers to provide patient care for maternal and child health populations and used resources to offset the cost on a fee-for-service basis. The community health centers and OMCFH have a symbiotic relationship that works to the mutual benefit of all, the patient, the health center and the Office. For example, the largest provider of family planning services are the community health centers.

The community health center network operates more than 106 health care sites across the state which includes school-based health centers and multiple free clinics. The purpose of the School-Based Health Center Program is to provide easy access to preventive and primary health care for school-age children at their local elementary, middle, or high school. These centers are operated and administered by a community-based healthcare clinic in their area. Each center is located within the school building, or on the school campus. When the school is closed, the student may seek care at the healthcare clinic which operates their school's center. Currently, funding is provided through the Division of Primary Care to 49 school-based health centers serving 64 schools in 24 counties, making health services available to over 25,000 students. Also, funding is provided to one more primary care organization which supplies referrals to the students at 3 high schools in their county. Additional school-based health centers are planned.

Each student receiving services at a school-based health center must be enrolled with written parental permission. Follow-up with the parent/guardian is conducted at the time of service, or immediately following. Services which may be provided by a school-based health center include: preventive education, yearly physicals, immunizations, chronic disease management, check-ups, acute and intermediate care, oral health, mental health, counseling, and ancillary and enabling services.

According to 2008 Census data, 15% of the population in the state does not have health insurance. In March 2006, West Virginia Governor Joe Manchin lll signed legislation to expand SCHIP eligibility up to 300 percent of the federal poverty level, and on January 1, 2007, the state began a phase-in expansion by enrolling children in SCHIP with family incomes up to 220 percent of the federal poverty level. Adoption of this change is estimated to provide comprehensive health care coverage to approximately 400 uninsured children of working families during the first year of implementation. WVCHIP expanded the upper income limit to cover families with incomes at 250% of poverty January 1, 2009.

West Virginia reached its population peak a half century ago with 2,005,552 residents counted in the 1950 Census. The state's population has not exceeded the two million mark since then, but has fluctuated between 1.7 and 1.9 million depending on the state's economy. Four of the state's five largest cities have lost population since 1990. Charleston, the state capitol and largest city, and Huntington are the only places with populations exceeding 50,000. Population estimates from U.S. Census show West Virginia among the most racially homogeneous states in the country. The 2000 census reported that 95.9% of WV residents are Caucasian, 3.5% Black or African American, 0.6% American Indian and Alaska Native, 0.7% Asian and 0.3% some other race.

West Virginia now has the distinction of having the oldest median age in the nation (38.1 years). West Virginia has the highest median age in the nation at 38.9, and the state's percent of people age 60 and older is ranked second in the nation. Between 1990 and 2000 people 85 and older increased by 24.8%; the number of individuals age 90 and older grew by 41.3%. Although the population has fluctuated between 1.8 and 2.0 million over the last 50 years, the rate of births have declined from 50,000 births in 1950 to 20,000 births in 2001 dropping from a rate of 25.4 births per 1,000 to 11.3 births per 1,000. In 1997 West Virginia saw its first natural decrease,

having 137 more deaths in that year than births, the first state in the nation to experience such a phenomenon. This trend continued through 2003. Because of its older population, West Virginia ranked first among the states in 1998 in the percentage of its residents enrolled in Medicare (18.4%, compared to a national average of 13.9%). Older West Virginians value their independence, self-sufficiency and preservation of the family homestead. This lifestyle is demonstrated by the fact that residents maintain the highest percent of home ownership in the nation at 75.17%. Almost 85% of individuals age 65 and older own their home.

Over the past 30 years the dominant industries in West Virginia have shifted from mining and manufacturing to services and service producing jobs. Traditionally, mining and manufacturing wage scales are much higher than those in service occupations and include benefits such as medical, dental, and vision plans. Service jobs, on the other hand, are often part-time and do not include insurance plans. The low wages earned at such jobs often do not allow individuals to purchase their own health insurance coverage.

West Virginia's unemployment rate for March 2010 was 10.1% compared with a national rate of 10.2%. Workforce West Virginia April 2010 data indicate that seasonally adjusted unemployment rates were at 9.2% with the national rate at 9.9%. State and federal minimum wage remained the same at $7.25 per hour.

Work disability is a significant problem in West Virginia. The U.S. Census Bureau states in 2000, 22.5% of the population 16-64 years of age had a disability, and 13.2% had a work disability.

Because of the loss of higher paying jobs over the past thirty years in West Virginia, there has been a concurrent rise in the state's poverty rate. According to figures supplied by the U.S. Census Bureau and reported in the State Rankings 2002 (published by Morgan Quitno), West Virginia continued to rank fifth in the nation at 17.2% of the state's residents living in poverty, compared to the national average of 12.4%. In 2000 the median household income in West Virginia was $36,484. Of residents age 65 and older, 11.9% are living below the poverty level, while 16.0% of children age 18 and under are living in poverty. The percent of high school graduates or higher, of the population 25 years and over, is 75.2%.

Governor Joe Manchin III developed the West Virginia Kids First Screening Initiative so that children could benefit from a caring health professional working closely with their parents and school. The Kids First Screening Initiative unites parents, health professionals and teachers to give West Virginia's children the positive start in life they deserve by working together to assure WV children entering kindergarten are healthy and ready to learn. Every child, at first school entry, receives comprehensive screening that includes hearing, speech, language, and growth and development using the EPSDT/HealthCheck protocol. Beginning with the 2008-09 school year, all school enterers received this wellness exam.

According to America's Promise Alliance, children need "Five Promises" to succeed in life. Since his inaugural speech in 2005, Governor Manchin asked that we unite as a state in committing ourselves to keeping these five promises for our children. The promises are: 1. Caring adults 2. Safe places 3. A healthy start 4. Effective education 5. Opportunities to help others. The Kids First Screening Initiative is a part of keeping these valuable promises for the children of West Virginia. The Office Director of OMCFH was intimately involved in the design and development of this project. The KIDS First screening initially began screening only school enterers but legislation is pending to include children in third, sixth and ninth grades.

In the last ten years the number of cases of autism spectrum disorder has grown from one in 500 to one in 100 children across the nation. This disorder has huge implications for state governments and the health care economy. WV, like state governments across the country, is grappling with policy questions of who is going to pay, how can services be coordinated, and how can we ensure evidence-based interventions are available to families.

The last two legislative sessions, autism bills have been introduced, each time without passage. The bills had provisions requiring insurance coverage for the diagnosis. Advocates for the legislation argued that twelve states already require private health insurers to cover autism treatments. Insurance lobbyists argued that the legislation was an attempt to shift responsibility for services from school systems to the health care systems. Obviously the health and educational challenges of autism are inextricably intertwined.

State efforts in regards to this growing concern includes: 1)Part C/IDEA - West Virginia Birth To Three; 2)Medicaid Waivers, not to be confused with a specific Autism Waiver; 3)Marshall University - Autism Training Center; 4)West Virginia University (WVU) Center for Excellence in Disabilities - formerly the UAP; and 5)Education. Basically, all the above are trying to address services for people with autism, but there is no master plan or coordinating body.

The Office of Maternal, Child and Family Health operates in partnership with the federal government and the state's medical community, including private practicing physicians, county health departments, community health centers, hospitals and various community agencies to address West Virginia residents' needs.

The Office of Maternal, Child and Family Health strives to provide the necessary education and access to treatment needed in order for our residents to make informed decisions regarding their own individual health needs. Categorical programs to address specific needs for targeted groups are limited with 80 percent of the Office's energy being used to develop systems for the provision of population-based and target specific preventive interventions, as well as infrastructure for the support of the maternal, child and family health populations.

Availability of services for West Virginia's MCFH population has increased dramatically, however, there remain areas of the state that continue to lack medical practitioners. In addition, meeting the needs of chronic or disabled populations is impaired by the lack of medical sub-specialty providers, such as occupational therapists, physical therapists, speech pathologists, dentists; and as is typical with most states, pediatric sub-specialties are mostly available at tertiary care sites. To attend to these problems, the Bureau for Public Health, in collaboration with the West Virginia University School of Medicine, sponsors a rural practice rotation for physicians, social workers, dentists and other specialty providers, with the intent of encouraging the establishment of rural practices, as well as expanding immediate service capability, since these practitioners render hands-on care.

The Perinatal Partnership found that many providers, especially at small rural hospitals, complained that pregnant women and/or their newborn infants needing tertiary care were being turned away due to a lack of bed capacity at the three tertiary care centers in the state. Further study demonstrated this to be true and that the Neonatal Intensive Care (NICU) facilities have been functioning at 100 percent capacity. Physicians with the tertiary care facilities reported that they were turning away both high-risk maternal transports and infant transports, primarily due to no availability of NICU beds.

The Partnership's Committee on Adequacy of NICU Beds recognized that the cost to operate NICU beds and the physical capacity of some tertiary facilities to add more beds posed problems. At the same time, it was of utmost importance to care for newborns as close to home as possible and it was recommended that the tertiary care facilities seriously study their capability to increase NICU beds. To assist in accomplishing this, it was recommended that the West Virginia Health Care Authority should immediately evaluate and update the current methodology utilized in determining Certificate of Need approval of NICU beds. The need to upgrade some community hospitals and equip them to handle newborns needing added care but not necessarily needing transfer to a NICU was discussed. Also, community hospitals could be upgraded to handle NICU "back referrals" for infants needing intermediate but not intensive care. Community hospitals that had the capacity or were willing to upgrade their capacity to accommodate infants that needed added care as they transition into health were asked to begin addressing this issue.

The Perinatal Partnership noted that to avoid unnecessary admissions to NICU, each birthing facility and all maternity providers should curtail elective delivery prior to 39 weeks gestation thus implementing ACOG recommended guidelines for elective delivery.

Between 2004 to 2007, the state's three tertiary care facilities were at NICU bed capacity with just 89 NICU licensed beds. In 2009 the number of beds increased to a total of 118. Between October 2007 and October 2008, 31 infants were turned away from one of the three NICU's due to lack of bed availability. This information was presented to the Legislative Oversight Committee on Health and Human Resources in an effort to increase attention to perinatal system shortcomings in West Virginia and resulted in expansion of the NICU bed capacity.

West Virginia House Bill 2388 established a mandate for the universal testing of newborns for hearing loss. The Newborn Hearing Screening Advisory, as established in statute, has made testing recommendations, developed screening protocols, and assisted the Office of Maternal, Child and Family Health with the development of user friendly education materials for inclusion in hospital birth packets and distribution through the state's perinatal program called Right From The Start (RFTS). The passage of the West Virginia Birth Score, in this same legislation, further strengthened the state's ability to universally screen all newborns for developmental delay, hearing loss, and conditions that may place infants at risk of death in the first year of life. The original birth score instrument was modified to accommodate hearing screening, so one instrument and one tracking system addresses the mandate. All WV birthing facilities began universal newborn hearing screening effective July 1, 2000. The Birth Score Office and the OMCFH newborn hearing screening project coordinator offer on-going technical assistance related to the operation of the initiative.

In 2002, three additional bills were passed: SB 672 establishing a Birth Defects Surveillance System, HB 216 requiring screening of all children under the age of 72 months for lead poisoning, and HB 3017 requiring the creation of a state oral health program. Although all of these programs existed previously, legislative mandates ensure continuance of these health efforts.

The 78th West Virginia Legislature, passed in the 2007 session, H. B. 2583 mandating the expansion of newborn screening to include 29 disorders. The West Virginia Newborn Screening Program, housed within the Office of Maternal, Child, and Family Health within the Bureau for Public Health, partnered with the State Laboratory to expand newborn screening to include the twenty-nine disorders in order to adhere to national standards recommended by the United States Department of Health and Human Services, Secretary's Advisory Committee on Heritable Disorders and Genetic Diseases. The Bureau for Public Health submitted legislative rules that allowed for financial sustainability by invoicing the hospitals for each live birth receiving a screen. The fee charged is based on cost and will be sufficient to cover the cost of the newborn metabolic system. Screening for all 29 newborn disorders became effective February 4, 2009.

On April 1, 2009, states began to receive education and childcare funds appropriated under the American Recovery and Reinvestment Act. Several states, including West Virginia, want to use the money to improve childcare and information technology so longitudinal data about school enterers is available for planning purposes.

West Virginia purchased Ages and Stages in 2009 for use by childcare, medical practitioners, and the IDEA/Part C system to improve early identification efforts of children experiencing delay. Social and Emotional stages kits were also purchased in April 2010. There is also discussion about monies being dedicated to quality improvement in early childhood care centers, since three quarters of the nation's children between the ages of 3 and 5 and more than half of the children ages 2 and under spend time in some form of non-parental care. Many of these children are cared for by relatives, but a large proportion - 57% of children aged 3 to 5 and 20% of infants and toddlers are in center-based care. The quality of care in childcare settings varies dramatically, with low income children generally receiving the lowest quality care. We see the voluntary

participation in statewide Quality Rating and Improvement Systems the best way to improve the overall level of quality.

Childhood is a unique and valuable stage in the human life cycle. The most important influence in the life of a young child is the family. Parent education and home visiting programs strengthen the family and support parents. Many early childhood home visiting programs focus on families who are at risk, such as young, first-time mothers, mothers of low birthweight infants and low income families. West Virginia RFTS Program focuses on low income, medically high risk pregnant women, its goal is improving pregnancy outcome and infant well-being, and is managed by the OMCFH in partnership with licensed nurses and social workers employed by community-based agencies statewide. BTT, while not a home visiting program, also serves 98% of the eligible population of developmentally delayed infants and toddlers under age three years in their home. This Program is considered educational in nature, has no income guidelines, and is for a subset of the population. Nevertheless, BTT (Part C/IDEA) is an investment in early childhood, administered under the U.S. Department of Education/Office of Special Education Programs' guidelines by the OMCFH.

Other home visiting programs in West Virginia support parents and caregivers in preparing children for school entry and lower risks associated with growing up in poverty. The multiple programs serving early childhood populations provide unique opportunities for overall improvement in child and family well-being. Fortunately, no one program is expected to serve the total population of children birth to six years of age. However, there is often competition for scarce fiscal resources and confusion about what constitutes a home visiting program compounded by service competition for populations; i.e., pregnant women and infants.

Following is a Vital Statistics Summary:

Population
In 2008, eleven West Virginians were lost to the total population as a result of natural decrease, the excess of deaths over births. Results from the 2008 Census estimate show an overall increase (approximately 0.3%) in the state's population since 2000, from 1,808,344 to 1,814,468. This increase is the result of a slight growth in the excess of in-migration over out-migration during that span, as well as the natural increase.

Although there is an increase in the overall population from 2000 to 2008, only 20 of the state's 55 counties have shown an increase. Furthermore, only three of the state's 25 largest cities have shown an increase in population since the 2000 Census. The U.S. Census Bureau estimates the population during non-Census years (www.census.gov). These updates are officially announced as of July 1 of every year until the decennial Census which is on April 1 each 10 years. Every year, the actual estimates change from previous years but vintage years are still available on their website.

Live Births
West Virginia's resident live births decreased by 525 or 2.4%, from 22,017 in 2007 to 21,492 in 2008. The 2008 birth rate also decreased 3.3% from 12.2 per 1,000 population in 2007 to 11.8. The U.S. 2007 birth rate was 14.3 live births per 1,000 population rising slightly above the 2006 rate of 14.2. West Virginia's birth rate has been below the national rate since 1980. It continued its overall decline until 1996, interrupted by slight upturns in 1989 through 1991. It remained relatively stable from 1996 to 2006 and 2008 with an increase in 2007.

The 2008 U.S. fertility rate of 68.4 live births per 1,000 women aged 15-44 was slightly lower (1.6%) than the 2007 rate (69.5). West Virginia's fertility rate decreased 1.4%, from 63.1 in 2007 to 62.2 in 2008. The fertility rate among women aged 15-19 in West Virginia was 15.3% higher than that among young women in the U.S. (49.0 vs. 42.5). The fertility rate among women aged 20-44 was lower by 13.4% in the state than in the nation (64.7 vs. 74.7).

The number of births to teenage mothers (ages 10-19) increased by 44 (1.6%), from 2,737 in 2007 to 2,781 in 2008. The percentage of total births represented by teenage births was higher in 2008 than 2007 (12.9% vs. 12.4%). The significantly lower fertility rate among older women, however, resulted in teenage births continuing to constitute a higher proportion of total births than was found nationally (10.5% in 2007).

The percentage of births occurring out of wedlock continued to rise in 2008. Over two of every five (41.9%) West Virginia resident births were to unwed mothers. The percentages of white and black births that occurred out of wedlock in West Virginia in 2008 were 40.8% and 75.2%, respectively, compared to 39.2% and 73.4% in 2007. In the United States in 2007, 27.8% of white births (non-Hispanic) and 71.6% of births to black mothers (non-Hispanic) occurred out of wedlock. The percentage of teenage births to unmarried teenage mothers in the state decreased slightly from 80.8% in 2007 to 80.5% in 2008.

There was a total of 2,050 low birthweight babies (those weighing less than 2,500 grams or five and a half pounds) born to West Virginia residents in 2008, 9.5% of all births. Of the 2,050 low birthweight infants, 1,354 or 66.0% were preterm babies born before 37 weeks of gestation. (Of all 2007 resident births with a known gestational age, 11.8% were preterm babies.) Of the births with known birthweight, 9.4% of babies born to white mothers and 14.5% of babies born to black mothers were low birthweight. Nationally, 8.2% of all infants weighed less than 2,500 grams at birth in 2007; 7.2% of white infants and 13.8% of black infants were of low birthweight.

Eighty percent (80.8%) of 2008 West Virginia mothers with known prenatal care began their care during the first trimester of pregnancy, compared with 83.2% of mothers nationwide in 2006 (the latest data available). Among those with known prenatal care, 81.3% of white mothers began care during the first trimester; 70.0% of black mothers did so. (U.S. figures show that 88.1% of white mothers and 76.1% of black mothers had first trimester care.) No prenatal care was received by 0.6% of white mothers and by 1.9% of black mothers.

Over one-fourth (27.0%) of the 21,492 births in 2008 were to mothers who smoked during their pregnancies, while 0.3% of births were to women who used alcohol. National figures from 2005 show that 10.7% of women giving birth reported smoking during pregnancy; 0.8% used alcohol in 2004 (the latest data available). Among the state mothers who reported smoking during pregnancy, 14.0% of the babies born were low birthweight, compared with 7.9% among non-smoking mothers. Over one-third (35.7%) of 2008 state births were delivered by Cesarean section, compared with a 2007 national rate of 31.8%. One or more complications of labor and/or delivery were reported for 32.2% of deliveries in the state in 2007.

Deaths

The number of West Virginia resident deaths increased by 435, from 21,067 in 2007 to 21,502 in 2008. The state's crude death rate rose from 2007 at 11.6 per 1,000 population to 11.8 in 2008. The average age at death for West Virginians was 72.5 (69.0 for men and 75.9 for women), slightly higher than the 2007 average of 72.0 (68.4 for men and 75.6 for women). One hundred and fifty West Virginia residents who died in 2008 were age 100 or older. The oldest man and woman were 109 years old at the time of death.

Heart disease, cancer, and chronic lower respiratory diseases, the three leading causes of death, accounted for 53.6% of West Virginia resident deaths in 2008. Compared with 2007, the number of state deaths due to heart disease increased by 65 or 1.2% while cancer deaths decreased 1.2%. Chronic lower respiratory disease, the third leading cause, increased 15.7%; while stroke mortality, now the fifth leading cause, decreased 6.5%. Diabetes mellitus deaths decreased 8.1%, while the number of reported deaths due to pneumonia and influenza increased 8.6%. Dementia, now the sixth leading cause of death in the Mountain State, continues to increase at 22.2%, while Alzheimer's disease increased 15.7%. Accidental deaths were the fourth leading cause of death for the second year in a row. The number of accidental deaths dropped by 51 (4.3%), from 1,242 in 2007 to 1,191 in 2008. Motor vehicle accident deaths decreased by 46 or

12.1% from 425 in 2007 to 379 in 2008. Accidental poisoning deaths have been on the rise in West Virginia for five of the previous six years, increasing by 37 (8.3%) from 407 in 2007 to 444 in 2008. The vast majority of these deaths were due to both legal and illicit ingestion of prescription pharmaceuticals.

Accidents were the leading cause of death for ages one through forty-four years. Motor vehicle accident fatalities remained the single leading cause of death for young adults aged 15 through 24, accounting for 35.6% of all deaths for this age group in 2008. West Virginia's 2008 motor vehicle fatalities included five children under five years of age, one less than 2007. Accidental poisoning accounted for over one-fifth (21.0%) of all deaths in the age group of 25-34.

Suicides decreased by 28, from 312 to 284 between 2007 and 2008. Male suicides decreased by 38 or 14.6 %, from 261 in 2007 to 223 in 2008; the number of female suicides (61) increased by ten or 19.6% from 2007. Over two-thirds (66.9%) of all suicide deaths were firearm related -- 72.6% of male suicides and 45.9% of female suicides. The average age of death for a suicide victim in 2008 was 46.9 years. While suicide was the 12th leading cause of death overall, it was the third leading cause of death for ages 15-34. The number of suicides among persons aged 19 and under was 9 in 2008, same as 2007.

Homicides decreased by 19, from 94 in 2007 to 75 in 2008. Forty-seven (47) of the homicide victims were male, 28 were female. The average age at death for a homicide victim in 2007 was 39.1 years. There were 7 homicide victims under the age of five in 2008, compared with 11 in 2007. Over half (50.7%) of 2008 homicide deaths were due to firearms.

Years of Potential Life Lost (YPLL)
YPLL is a measure of mortality, calculated as the difference between age 75 (an average life span) and the age at death. Using YPLL before age 75, the sum of YPLL across all causes of death represents the total YPLL for all persons dying before the age of 75. A person dying at the age of 45 would therefore contribute 30 years to the total YPLL (75-45=30). YPLL is an important tool in emphasizing and evaluating causes of premature death.

The YPLL from all causes decreased 2.3%, from 173,739 YPLL in 2007 to 169,793 in 2008. The four leading causes of YPLL in 2008 were malignant neoplasms (36,151 YPLL), diseases of the heart (24,334 YPLL), non-motor vehicle accidents (20,528 YPLL), and motor vehicle accidents (12,099 YPLL). Combined, these four causes accounted for over half (54.8%) of all years of potential life lost in 2008. In comparison to 2007, YPLL attributable to malignant neoplasms increased from 20.6% to 21.3%. YPLL due to diseases of the heart decreased from 14.6% to 14.3% of the total, and YPLL due to non-motor vehicle accidents increased from 11.9% to 12.1%. The percentage of total YPLL due to motor vehicle crashes decreased, from 8.4% to 7.1%.

Infant Deaths
Deaths of infants under one year of age rose by 3, from 163 in 2007 to 166 in 2008. West Virginia's infant mortality rate also rose from 7.4 per 1,000 live births in 2007 to 7.7 in 2008. The U.S. infant mortality was 6.7 in 2007 (the latest data available).

The state's 2008 white infant mortality rate increased from 6.9 in 2007 to 7.3, while the rate for black infants decreased slightly from 22.0 to 21.0.

Over one out of six (18.7%) infant deaths in 2008 were due to SIDS (sudden infant death syndrome). Approximately one in four (23.5%) was the result of congenital malformations, while 41.0% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birthweight (7.2%).

Neonatal/Postneonatal Deaths
The number of neonatal deaths dropped by 7, from 103 in 2007 to 96 in 2008; the neonatal death rate also decreased, from 4.7 deaths among infants under 28 days per 1,000 live births in 2007 to

4.5 in 2008. Neonatal deaths comprised 57.8% of all West Virginia resident infant deaths in 2008, compared with 63.2% in 2007. The rate of postneonatal deaths increased from 2.7 deaths per 1,000 neonatal survivors in 2007 to 3.3 in 2008. The 2006 U.S. neonatal death rate was 4.6, while the postneonatal rate was 2.3 deaths per 1,000 neonatal survivors. U.S. neonatal and postneonatal data for 2007 or 2008 were not available at the time of this publication.

Fetal Deaths

The 94 resident fetal deaths occurring after 20 or more weeks of gestation reported in 2008 were 22 less than in 2007 (116). The fetal death ratio also decreased, from 5.3 deaths per 1,000 live births in 2007 to 4.4 in 2008. The majority (89.4%) of fetal deaths were due to conditions originating in the perinatal period, including complications of placenta, cord, and membrane (37.2%), maternal conditions (6.4%), maternal complications (9.6%), short gestation and low birthweight (6.4%), and other ill-defined perinatal conditions (20.2%). Congenital anomalies accounted for 10.6% of all fetal deaths.

Induced Termination of Pregnancy (ITOP)

The annual reporting of induced termination of pregnancy (ITOP), also properly referred to as "induced abortion," was mandated in the latest revision of the West Virginia Code. An ITOP is a purposeful interruption of an intrauterine pregnancy with the intention other than to produce a live-born infant and which does not result in a live birth. The management of prolonged retention of products of conception following fetal death is excluded. The major distinguishing feature of this event is the fact that it is "purposeful" rather than spontaneous. A spontaneous interruption of a pregnancy is also known as a fetal death or a spontaneous abortion or, more commonly, as a miscarriage or a stillbirth.

One of the primary differences between the reporting of ITOP data and birth and death statistics is that ITOP statistics reflect events that occurred in West Virginia. Due to long standing inter-jurisdictional exchange agreements with other states, births and deaths to West Virginia residents that occur elsewhere are reported back to West Virginia, making it possible to ascertain the number of births and deaths among West Virginia residents in a given time frame regardless as to where the event occurred. Information on the number of West Virginia residents who obtain an ITOP in another state is infrequently reported back to West Virginia by the state where the procedure took place, normally due to restrictions within the other state's legal code.

The only two free-standing clinics that perform ITOPs on demand in West Virginia are in Charleston, which makes the likelihood of out-of-state ITOPs greater in some regions of the state. It is unlikely that the majority of women living in the northern or eastern panhandle of the state seek an ITOP in West Virginia. Due to known incomplete reporting, therefore, the procedures performed on West Virginia residents in other states have been excluded from the compiled statistics.

In 2008, there were 1,982 ITOPs performed in West Virginia, 7.2% more than in 2007 (1,849). Nearly eight out of every nine (88.2%) 2008 ITOPs involved a West Virginia resident, while 5.8% were Ohio residents and 4.8% were residents of Kentucky, compared with 2007 percentages of 89.7%, 5.8%, and 3.7%, respectively. The median age of women having an ITOP in 2008 was 24, compared to 23 in 2007. There were 117 procedures in 2008 involving females under the age of 18, of which 102 were to unemancipated minors compared with 122 in 2007, of which 119 were unemancipated minors. Nearly eighty-five (84.8%) percent of the 2008 ITOPs performed in West Virginia were to women who were not married at the time with the majority of these women (80.6%) having never married. Only one-third (33.7%) of the 2008 ITOPs performed in West Virginia were to women who had never had any previous live births while over half (55.0%) were to women who had two or fewer children. There were seven ITOPs performed where the women had six or more children. Over sixty percent (62.3%) of the 2008 ITOPs performed in West Virginia were to women who had never had a previously induced ITOP while over one-third (34.3%) were to women who had two or fewer previous ITOPs. There were five ITOPs performed where the women had six or more previously induced ITOPs.

Marriages
For the seventh time in the past eight years, the number of marriages in West Virginia decreased, from 13,308 in 2007 to 12,980 in 2008. The marriage rate in 2008 was 7.2 per 1,000 population; slightly lower than the 2007 rate of 7.3. The 2007 U.S. provisional rate was 7.3.

For all marriages in 2008, the median age was 26 for brides and 29 for grooms. The mode (most frequently reported age) for all marriages was 22 for brides and 25 for grooms. There were 181 brides less than age 18 while there 27 grooms. There were 164 brides over the age of 65 while there were 311 grooms. Also in 2008, there were 195 marriages where the groom was 20 years or more older than the bride while there were 30 marriages where the bride was at least 20 years older.

For first marriages, the median age for brides was 22; for grooms it was 24. The mode for first marriages in West Virginia was again 22 for brides and 25 for grooms. All of the West Virginia brides and grooms less than age 18 were in their first marriage. There were nine brides over the age of 65 while there were three grooms in their first marriage. In cases where it was the first marriage for either the bride or groom in 2008, there were 97 incidences where the groom was 20 years or more older than the bride while there were 21 marriages where the bride was at least 20 years older. However, in cases where it was the first marriage for both the bride and groom in 2008, there were 14 incidences where the groom was 20 years or more older than the bride while there were only two marriages where the bride was at least 20 years older.

Divorces and Annulments
The number of divorces and annulments decreased by 402 or 4.3%, from 9,305 in 2007 to 8,903 in 2008. The 2008 rate of 4.9 per 1,000 population was also lower than the 2007 rate of 5.1.

Of the 8,903 divorces in West Virginia in 2008, the median duration of marriage was six years. Approximately one out of every six (17.7%) West Virginia divorces with a known duration in 2008 occurred where the marriage lasted only two years or less while 7.7% occurred where the duration of marriage was 25 years or longer. There were 13 divorces involving a wife less than age 18 while there was only one where the husband was under age 18.

Over half (53.6%) of the divorces involved no children under 18 years of age in the family, while one child was involved in 22.2% of all divorces and two children were involved in 17.7%. Seven divorces involved six or more children.

B. Agency Capacity

The Office of Maternal, Child and Family Health has historically purchased and/or arranged for health services for low income persons, including those who have health care financed under Title XIX. The Medicaid expansion of the 1980's resulted in health financing improvements, but it was Title V energy that developed obstetrical risk scoring instruments and recruited physicians to serve mothers and children, including those with special health care needs. It was also Title V that established standards of care, and developed formalized mechanisms for on-site quality assurance reviews.

Income eligibility coverage for pregnant women is 185% of the Federal Poverty Level in response to patient demand, using Title V monies. Although the Office of Maternal, Child and Family Health is less and less involved as a health care financier, we continue to provide gap filling services when indicated.

The OMCFH is constituted of three divisions, plus a Quality Assurance/Monitoring Team,

Provider Education and Recruitment Unit, Early Intervention IDEA/Part C, and an Administrative Unit. With the exception of the Children with Special Health Care Needs Program, the Office of Maternal, Child and Family Health does not deliver direct services but rather designs, oversees and evaluates preventive and primary service systems for West Virginia women and men of reproductive age, infants, children, adolescents, and children with special health care needs.

Quality Assurance/Monitoring Unit:
The OMCFH Quality Assurance/Monitoring Team has over 25 years proven experience in conducting on-site clinical reviews. These reviews occur with every medical and educational provider who contracts with the Office - private physicians, primary care centers, local health departments, hospitals, etc. The reviews are conducted on site and include patient interviews, chart reviews, and provider interviews. Formal reports are submitted to each program, as well as the health care provider.

Division of Perinatal and Women's Health:
The focus of the Perinatal and Women's Health Division is to promote and develop systems which address availability and accessibility of comprehensive health services for women across the life span and high risk infants in the first year of life. Administrative oversight includes an integrated perinatal care and education system paid for by Title V and Title XIX. Perinatal and Women's Health programs include the Family Planning Program under which the Adolescent Pregnancy Prevention Initiative is housed; the Breast and Cervical Cancer Screening Program; WISEWOMAN; and the Right From The Start (RFTS) Perinatal program that includes the Newborn Hearing Screening Project and the Birth Score Project. Additionally, these programs provide linkage and referral to other women's, infants', and children's services.

Family Planning Program:
The Family Planning Program (FPP) provides an array of confidential preventive health services for low-income women, men and adolescents through a community-based provider network of locations. Sites include county health departments, primary care centers, hospital outpatient centers, private providers, free clinics and university health sites. FPP services include contraceptives; health histories; gynecological exams; pregnancy testing; screening for cervical and breast cancer; screening for high blood pressure, anemia, and diabetes; screening for STDs, including HIV; basic infertility services; health education and counseling, and referrals for other health and social services. Free or low cost pregnancy testing is offered to enable early identification of pregnancy and timely referral into prenatal care.

For more than three decades, the WV Family Planning Program has been an integral component of the public health system, providing high-quality reproductive health services and other preventive health care to low-income or uninsured individuals who may otherwise lack access to health care. Subsidized medical care provided by Family Planning Program clinics prevents unintended pregnancies, reduces the need for abortion, lowers rates of sexually transmitted diseases, including HIV, detects breast and cervical cancer at its earliest stages and improves the overall health of women, children and families.

Any female or male capable of becoming pregnant or causing pregnancy whose income is at or below 250% FPL is income eligible to receive free or low-cost clinical examinations and free contraceptives through the Family Planning Program. These publicly funded clinics help women prevent 13,800 unintended pregnancies each year.

Preconceptual Services:
Preconception care is a critical component of health care for women of reproductive age. The primary goal is to provide health promotion, screening, and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies. Preconception health care is critical because several risk behaviors and exposures affect fetal development and subsequent outcomes.

Family Planning Program clinics offer counseling and referral for patients regarding future planned pregnancies, management of current pregnancies, or other individual concerns (i.e., nutrition, sexual concerns, substance use and abuse, sexual abuse, domestic violence, or genetic issues). FPP clients seeking pregnancy or planning a pregnancy in the future are offered prenatal multi-vitamins with folic acid as part of their pre-conceptual counseling. Clients in need of enhanced preconception counseling or genetics testing are referred to tertiary care facilities or specialty providers for additional assessment.

Domestic Violence:
Screening for domestic and intimate partner violence continues to be monitored by the Family Planning Program. Family Planning Program Specialists inquire about screening and availability of resources for victims at annual site visits. Findings are documented in their reports and entered in a data base. All Family Planning Program providers (100%) provide resources on site for services to those who are victims of domestic or intimate partner violence.

A Domestic Violence Intervention Guide was developed within the FPP for use by clinicians. A poster was also created to be placed in the restrooms with tear-off safety-plans for victims to take with them. The intervention guides and posters with tear-off safety plans were mailed to all FPP provider sites and are available by request.

Adolescent Pregnancy Prevention Initiative:
The Adolescent Pregnancy Prevention Initiative (APPI) provides development, oversight and coordination of adolescent pregnancy prevention activities. As a focus area of the Family Planning Program, the goal of the Adolescent Pregnancy Prevention Initiative is to reduce the number of pregnancies among adolescents through improved decision-making skills, abstinence, and/or access to contraceptive services.

APPI is made up of 5 full-time employees: 1 Coordinator and 4 Adolescent Pregnancy Prevention Specialists, who conduct community education and outreach activities on a regional/local level. The Adolescent Pregnancy Prevention Specialists work to increase public awareness of problems associated with early sexual activity and childbearing and collaborate with existing community organizations to promote local activities for adolescent pregnancy prevention. APPI offers abstinence based education but includes information about contraceptives and access to family planning services.

Confidential access to Family Planning Program services is crucial in helping sexually active teenagers obtain timely medical advice and appropriate medical care to continue the decline in teen pregnancy and childbearing. Minor clients seeking reproductive health care can only be assured of confidential services by a Title X-funded Family Planning Program network provider.

Right From The Start:
West Virginia's RFTS was birthed in 1989 as a partnership between OMCFH and West Virginia Medicaid to provide access to early and adequate prenatal care to low-income pregnant women and infants. Currently, RFTS provides comprehensive perinatal home visitation services to low-income women up to sixty days postpartum and care coordination for Medicaid eligible infants up to one year of age. RFTS also provides direct financial assistance for obstetrical care for West Virginia pregnant women who are uninsured or underinsured and are above income guidelines for Medicaid coverage. These pregnant women may qualify for assistance for prenatal care if they are a West Virginia resident, have income between 150%-185% of the federal poverty level, are a pregnant teen age 19 or under, or are a non-citizen. Under this Title V funded service, women who have no funding source for prenatal care coverage or have not yet been approved for coverage can receive assistance for payment of their first prenatal visit, ultrasound, and routine laboratory procedures if ordered on their first visit.

The state is divided into eight regions for management of RFTS. Each region has a Regional Lead Agency (RLA) that provides a Regional Care Coordinator (RCC) to oversee the activities of

the community based Designated Care Coordinators (DCC). In addition to assigning patient referrals and promoting the project, the RCC coordinates training and education for DCC staff, and recruits obstetrical care providers and designated care coordination agencies.

Currently, there are 185 DCCs dedicated to the core public health function of assisting with access to early and adequate prenatal health care. In addition to RFTS DCCs, there are 69 obstetricians, nurse practitioners, nurse midwives and family practice physicians in WV and bordering states that have Letters of Agreement with the Project to provide quality obstetrical and delivery care to pregnant women.

RFTS SCRIPT:
West Virginia continues to have the highest rate of pregnant smokers in the U.S. To address this issue, RFTS adopted an intense smoking cessation initiative, the WV Right From The Start SCRIPT (Smoking Cessation/Reduction in Pregnancy Treatment). SCRIPT was developed by Dr. Richard Windsor, MS, PhD, MPH, George Washington University Medical Center, Department of Prevention and Community Health. The RFTS SCRIPT Program uses the 5 A's (Ask, Assess, Advise, Assist, Arrange), best practice method for smoking cessation education with pregnant women supported by the Treating Tobacco Use and Dependence: Clinical Practice Guideline, Agency for Healthcare Research and Quality and by the American College of Obstetricians and Gynecologists Bulletins.

The smoking cessation program was implemented statewide in West Virginia in January 2002, through the OMCFH and incorporated as protocol into the RFTS Project in October 2003. The WV RFTS SCRIPT uses the existing home visitation network and protocols established in the RFTS Project. Registered nurses and licensed social workers, DCCs, provide services to pregnant women and infants throughout West Virginia.

Sudden Infant Death Syndrome (SIDS)/Sudden Unexplained Infant Death (SUID) Project:
This project collects and reports data regarding the occurrence of SIDS/SUIDS deaths in the State. When a SIDS/SUID death is reported, a local health department nurse is contacted to make a home visit to interview and assess the needs of the parents. Educational and grief information is sent to the family upon request. Training is provided to emergency room personnel, police, and funeral home personnel to sensitize them and offer strategies for responding to families. The Project Coordinator, as well as, the OMCFH Director are members of the Child Fatality Review Team.

Newborn Hearing Screen:
The Newborn Hearing Screening (NHS) Project ensures that all children born in WV are screened at birth for the detection of hearing loss. Case management services are provided by the RFTS Program for every infant who either fails the hearing screen or is not screened prior to hospital discharge. The NHS Project has adopted goals set forth by Healthy People 2010 and the Centers for Disease Control and Prevention who recommend that all newborns be screened for hearing loss prior to one month of age, have an audiological evaluation by three months of age, and if needed, have appropriate intervention services by six months of age. Children in need of intervention are referred to Children with Special Health Care Needs and WV Birth to Three. Referrals are also made to the Ski*Hi Parent/Child Program for home-based family education and support for deaf and hard of hearing children and their families, administered by the WV School for Deaf and Blind.

ART:
Access to Rural Transportation (ART) provides payment for transportation of RFTS Maternity Services eligible clients to medical or other predetermined medical care appointments (i.e. childbirth classes). The provision of transportation assistance is important to the goal of improving pregnancy outcomes and to the wellness of women and infants in West Virginia. RFTS Maternity Services clients receive transportation assistance via the ART system while Medicaid eligible clients receive this coverage via the Non-Emergency Medical Transportation (NEMT) system.

Birth Score:
High risk infants are referred to RFTS by the WVU, Birth Score Program. The Birth Score Developmental Risk/Newborn Hearing Screen Instrument is a population-based assessment designed to identify infants at birth that may be at risk for developmental delay or death within the first year of life. Infants who are identified as high risk receive an accelerated number of six medical visits in the first six months of life. Other Medicaid-sponsored infants who are considered at risk are referred to RFTS from various sources for care coordination.

In 2007, the Birth Score Developmental Risk/Newborn Hearing Screen Instrument was revised and questions added pertaining to the mother's oral health and substance abuse during pregnancy. The numerical Birth Score was changed so that the newborn is considered High Birth Score if the score is 99 or greater. All WV birthing sites implemented the new Birth Scoring System August 1, 2007. All High Birth Score infants continue to be referred to the RFTS Project for care coordination from birth through age one year.

Breast and Cervical Cancer Screening Program:
The West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP) is a comprehensive public health program that assists uninsured/underinsured, low income women (at or below 200% of the Federal Poverty Level) between the ages of 25 and 64 in receiving quality breast and cervical cancer screening services. These services are offered through a statewide network of over 300 screening and referral providers. The WVBCCSP is funded through a federal cooperative agreement with the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program (NBCCEDP). West Virginia was one of the original eight states which received funding to implement this program in 1991. Today, the NBCCEDP spans all fifty states and the District of Columbia, five U.S. territories, and twelve American Indian/Alaska Native organizations.

Since its inception, the WVBCCSP has enrolled over 122,000 women into the Program and provided more than 135,000 mammograms, 236,000 clinical breast exams, and 237,000 Pap tests. Annually, the Program screens over 16,000 women. However, the Program does more than simply screen women. There are several core components of the WVBCCSP including: Program Management; Screening, Tracking and Follow-up; Surveillance/Data Management; Quality Assurance and Improvement; Professional Development; Recruitment; Partnerships; and Evaluation.

To assist NBCCEDPs in providing treatment to women diagnosed with breast and/or cervical cancer, the 2000 Congress gave states the option to provide medical assistance for treatment through Medicaid as a part of the passage of the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). West Virginia was one of the first states to take advantage of this opportunity. This means that when an uninsured woman under the age of 65 is diagnosed with breast and/or cervical cancer and/or certain precancerous conditions, she is eligible for a Medicaid card. The card will pay for all her health care services that are included in the Medicaid State Plan, not just those to treat the cancer diagnosis.

WISEWOMAN:
West Virginia's WISEWOMAN Program is a public health program that works with the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP) to provide women access to cardiovascular risk factor screening and lifestyle interventions. WISEWOMAN participants must be enrolled in the WVBCCSP and be between the ages of 40-64 years. As part of a WVBCCSP eligible woman's routine breast and cervical cancer screening exam, she will be provided blood pressure readings, total and HDL cholesterol screening, blood glucose screening, calculation of body mass index, assessment of smoking status, and evaluation of personal and family medical history. As follow-up to her screening exam, she will be offered risk reduction counseling and lifestyle interventions that will address nutrition, physical activity and tobacco use. The majority of WISEWOMAN provider sites are community health centers, since their federal assignment is

assuring health access, and this provides an opportunity to be identified as the woman's health home.

Division of Infant, Child and Adolescent Health:
The goal of this Division is to promote parent/professional collaboration through parent participation on advisories; develop and issue medical care protocols in collaboration with the medical community to ensure provision of quality community-based services for child populations; and develop patient education and outreach strategies to encourage use of preventive health care.

Adolescent Health Initiative (AHI):
This program, originally financed solely by Title V, to address the most prevalent health risks facing adolescents today, has become a part of a larger initiative within OMCFH financed by TANF resources. The primary goal of the AHI is to improve the health status, health related behavior, and availability/utilization of preventative, acute, and chronic care services among the adolescent population of WV and promote risk resiliency and strengthen youths' personal assets.

Formal work with the Adolescent Health Initiative began in 1988. Introduction of the developmental asset principles of Search Institute brought about a change in the mission in 1993. Search Institute identified 40 positive experiences and qualities everyone can bring into the lives of youth, called the developmental assets. Organized training opportunities are provided by a workforce hired from the community they serve and offered in the community that the youth live. This workforce, called Adolescent Health Coordinators, is located in each of the eight regions of the state. These Coordinators offer young people, parents, and other significant adults in a child's life skill building sessions on conflict resolution, communication, increased awareness of harmful consequences of substance use, and strategies to develop self-reliance and improve responsible decision making.

The West Virginia Abstinence Education Project (AEP):
Since the inception of the federal abstinence education funding, West Virginia has been at the forefront of administering these grant dollars by providing long-term, intensive programs in an asset development framework in public schools and community organizations. Abstinence education is primary health prevention that teaches youth the physical, emotional, social, intellectual, spiritual and financial benefits of abstaining from sexual activity. Abstinence Education federal funding expired on June 30, 2009. With no state funding available to support the program, the WV AEP closed and does not currently provide abstinence education services. However, federal funding was reinstated as part of Patient Protection and Affordable Care Act signed into law on March 23, 2010. The AEP hopes to resume programming beginning October 1, 2010.

EPSDT/HealthCheck:
The OMCFH administers the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for EPSDT members not enrolled in a health maintenance organization (HMO) statewide, for all children receiving Physician Assurred Access Services (PAAS) and children receiving SSI. The program is administered under an OMCFH contract with the state's Medicaid agency, Bureau for Medical Services. OMCFH has provided EPSDT administration for 30 years.

EPSDT's promise to children eligible for Medicaid is the provision of preventive health exams and treatment of all medical conditions discovered during the exam even if the service is not a part of the Medicaid State Plan. EPSDT services include: 1) one or more physical exams each year based upon an age dependent periodicity schedule; 2) dental services; 3) vision services; 4) immunizations; 5) hearing services; 6) laboratory tests; 7) treatment for any health problems discovered during the exams; 8) referrals to other medical specialists for treatment; 9) monitoring the child's growth and development; 10) follow-up check-ups; 11) health education and guidance; and 12) documentation of medical history.

Oral Health Program:
This program is responsible for the overall coordination of the State Strategic Oral Health Plan as well as the Children's Dentistry, Pre-employment and Donated Dental Projects. Children's Dentistry works in concert with other Office of Maternal, Child and Family Health programs, Head Start and the public schools to promote awareness and availability of dental health services as an integral part of preventive, primary health services through educational instruction. Oral health efforts are funded from Title V and State appropriation. The Program conducts needs assessments, provides fiscal resources to local communities to support learning opportunities for children and adolescents which encourage behavioral change; i.e., regular check-ups, brushing/flossing and use of mouth guards during sports activities. OMCFH has contracts with local health departments, primary care facilities and oral health care professionals to provide educational services and materials to all 55 counties in West Virginia. These local health departments and contracted dental hygienists are responsible for oral health education efforts that include working with the public school system. The Office has developed education modules approved by the WV Dental Association, and utilizes oral health supplies and education materials that are used in public school instruction. This Program also supports fluoridation and sealant efforts in the community, in addition to providing oral health supplies and education materials requested by various partners throughout the state. Donated Dental provides dental care for a limited number of low-income senior citizens and adults who have disabilities. Pre-employment Services provides dental and vision services for eligible individuals who are receiving TANF benefits from DHHR.

Early Childhood Comprehensive Systems (ECCS):
The purpose of ECCS is to build and integrate early childhood service systems that address the critical components of access to comprehensive health services and medical homes; social-emotional development and mental health of young children; early care and education; parenting education; and family support.

Children With Special Health Care Needs:
The Children with Special Health Care Needs (CSHCN) Program is housed within the Division of Infant, Child and Adolescent Health. CSHCN has a strong care coordination component, providing care coordination services to children, age birth to 21, who have a variety of health care payers such as WV Medicaid, CHIP, PEIA, Blue Cross Blue Shield, Title V and other forms of insurance. The Program is structured to be community based and family-centered. CSHCN clinics are established statewide, as well as in collaboration with some of the tertiary care centers, to provide services as close to family residence as possible. In addition to contracted specialty physicians, clinics are also staffed by nurses, social workers and support staff who work as a multi-disciplinary team to provide health care management services and psycho-social support. These services include: assistance with obtaining durable medical equipment; development of individualized care plans and assessments; arrangements for follow-up care; assessment of daily living skills; assistance with transportation; and assistance with transitioning to adult living and workforce entry. The OMCFH continues to work diligently with members of the SSI/OMCFH Task Force to formalize outreach and agency linkages to achieve awareness/knowledge of who and how programs can be accessed. While this cooperative agreement encompasses all children with disabilities, initial efforts in 1996 targeted low birthweight babies and early intervention eligible children (birth to three years of age). More recently, the Task Force began efforts to ensure that children with disabilities who are within transitional age groups (specifically, three to six years and 16 to 21 years) receive prompt, appropriate services to enable a smooth transition to school and/or the workplace. Through a cooperative agreement dating back more than twenty years between the Office of Maternal, Child and Family Health and Bureau for Medical Services-Medicaid, Children with Special Health Care Needs staff provide care management services to Title XIX sponsored children, which maximizes Title V monies for non-insured and/or underinsured, medically indigent children.

Parent Network Specialists System:

In conjunction with the West Virginia University Center for Excellence in Disabilities (WVUCED), Title V funds the Parent Network Specialists system. Five parents of developmentally disabled children serve an assigned regional area of West Virginia linking families to resources, information and community services. This network will be undergoing a rigorous strategic planning session in the summer of 2010 to better serve the needs of children and families.

Systems Point of Entry:
Systems Point of Entry serves as the centralized information, patient education distribution and referral center for the Office of Maternal, Child and Family Health. SPE is responsible for the intake and eligibility review for the Children with Special Health Care Needs (CSHCN) Program. SPE also does eligibility review for the Right From The Start (RFTS) Program for West Virginia residents who have been denied services through Medicaid for their pregnancy. Systems Point of Entry is very unique in that whenever any type of contact is made, whether, by phone on one of OMCFH's two toll-free lines, email, or applying for one of the various programs, SPE focuses on the overall needs of the client/family, making community referrals whenever appropriate.

Toll-Free Lines: Referral Information Network (RIN)
Systems Point of Entry is responsible for the two phone numbers and four toll-free lines located in OMCFH. West Virginia callers are responded to Monday through Friday, except holidays, 8:00-5:00, by either a licensed social worker or a registered nurse. The two toll-free responders provide referrals and information to all of West Virginia free of charge. In 2009, there were 12,877 calls received on the toll-free lines.

WV Birth to Three/Part C IDEA:
Provides therapeutic and educational services for children age 0-3 years and their families who have established, diagnosed developmental delays, or are at risk of delay through a network of credentialed practitioners statewide. The goal is to prevent disabilities, lessen effects of existing impairments, and improve developmental outcomes. Services are provided based on individual child/family assessments and delivered by community-based practitioners who are credentialed by Birth to Three. The service system is supported by Title V, Part C, state appropriation and Title XIX.

Division of Research, Evaluation and Planning:
This Division is responsible for the epidemiological and other research activities of the Office of Maternal, Child and Family Health, including all programmatic data generation and program/project evaluation endeavors, as well as ensuring that the Office of Maternal, Child and Family Health's planning efforts are data-driven. All of the Office of Maternal, Child and Family Health's program specific databases are housed in this Division, and are linked with program leadership to assure consistent visioning.

The Division administers the Pregnancy Risk Assessment Monitoring System (PRAMS) Project, and the Childhood Lead Poisoning Prevention Project (CLPPP), sponsored by the Centers for Disease Control and Prevention (CDC); birth defects surveillance; and in conjunction with the Office of Laboratory Services, the Newborn Metabolic Screening Project, now supported by State funds and revenue generation. This Division is responsible for SSDI data integration activities and the Title V Block Grant application. The Division is also responsible for development of data applications and data analysis for OMCFH programs and projects.

Pregnancy Risk Assessment Monitoring System (PRAMS):
This is a population-based surveillance system of maternal behaviors and experiences before, during, and in the early infancy of the child. The Project is an integral component of the Office. Data and information gathered by the Project are used by the West Virginia Bureau for Public Health as a resource for both the development of maternal, child and family health programs and for evaluating the new and existing programs and projects. Some of the data gathered includes smoking during pregnancy, intendedness of pregnancy, entry into prenatal care, etc.

Newborn Metabolic Screening:
Expansion of newborn screening testing to include the 29 nationally recommended tests was mandated by the 2007 Legislature. Newborn screening rules were passed during the 2008 Legislative session mandating insurance companies to pay for system costs. In February 2009, WV began screening for all 29 of the nationally recommended disorders using the State Laboratory. Follow-up is provided by state office nursing personnel, in collaboration with the child's primary care physician. Children with inborn errors of metabolism receive special consultation through the WVU, Department of Pediatrics-Genetics Program, as part of a contractual agreement with OMCFH. Title V state office nurses track all medically prescribed food stuffs/formulas and have responsibility for assuring the timely shipment of formulas to families, in addition to coordination of care between the medical community and the family.

Genetics Project:
This project provides clinical genetic services preconceptually and for children with congenital defects at six satellite locations under the auspices of WVU, Department of Pediatrics. Services include diagnosis, counseling and management of genetically determined disease, prenatal diagnosis and counseling, and evaluation of teratogen exposure. These services are almost solely financed by Title V. The Genetics Program staff provides all technical guidance for the medical community caring for children with metabolic disease. With the expansion of newborn screening for metabolic diseases to meet the national standards, the Genetics Project has had to expand as well. WV only has one Geneticist and the WVU Department of Pediatrics is recruiting for additional physician positions. In order to meet current service demand, WVU has expanded the number of genetic counselors using OMCFH resources to support their salaries.

Childhood Lead Poisoning Prevention Project (CLPPP):
This Project is a collaborative effort between two Offices in the Bureau for Public Health, OMCFH and the Office of Environmental Health Services, funded by the CDC. An Advisory guides the operation of the Project, assisting the state with determining the extent of childhood lead poisoning in WV. To this end, extensive data gathering and analysis are routinely distributed. The Office of Environmental Health Services provides assessment of home and environment for residences of children with elevated blood lead levels.

Birth Defects Surveillance System:
Tracks the incidence of specific diagnostic codes using the birth files, death files and hospital charts of the infant as well as the mothers. All infants identified with a birth defect are referred to CSHCN for services and referrals. A CDC grant funded active case ascertainment in 2004 and 2005, but loss of that funding meant the closure of actively obtaining information from the medical record. Birthing facilities now send in monthly reports.

C. Organizational Structure

West Virginia's Office of Maternal, Child and Family Health is located within the state's Bureau for Public Health, administered by the umbrella organization, the Department of Health and Human Resources. The Bureau's overall goal is to attain and maintain a healthier West Virginia.

The Office of Maternal, Child and Family Health provides operational guidance and support to providers throughout West Virginia to improve the health of families. In addition to providing funding support for actual service delivery, the Office of Maternal, Child and Family Health funds projects intended to develop new knowledge that will ultimately improve the service delivery of the health community.

It is important to remember that improvement in the health of West Virginia's perinatal population is a result of a carefully crafted, highly-interdependent partnership. Tertiary care centers, primary care centers, local health departments, private practitioners and agencies have worked with the

Office of Maternal, Child and Family Health (OMCFH) for 30 years to make a difference in the health and well-being of the state's people. In conjunction with its medical advisory boards, OMCFH has designed a system that offers early and accessible health care to low income, medically indigent and under insured women and children.

Nationally, federal health agencies, insurance providers, health researchers, and policy groups are promoting the need for "Continuum of Care" with patients. It is recognized that continuity of coordinated, quality care is the best model of care for patients and is the most cost effective method for providing and paying for services. Continuum of care is best achieved through consistent access to quality health providers and services. Gaps in consistent care result in increased need for intensive and crisis care, which leads to higher costs for health care services. Research supports greater patient compliance with care plans when a positive relationship with their health care provider is well established. The Right From The Start (RFTS) Project has an established network of Registered Nurses and Licensed Social Workers who have provided this model of care since the 1980s.

Ensuring access to health care for low-income women and children has been an ongoing concern for state and federal officials. The Bureau for Medical Services (Medicaid) and the Office of Maternal, Child and Family Health (OMCFH) have worked collaboratively to develop special initiatives that extend support services to women and infants at-risk of adverse health outcomes. This partnership has not only expanded the state's capacity to finance health care for medically indigent women and children, but has also strengthened the delivery of care by establishing service protocols, recruiting medical providers and developing supportive services such as case management and nutrition counseling which contribute to improved patient well-being.

West Virginia Medicaid and the OMCFH share a common commitment to the goal of ensuring healthy births, reducing the incidence of low birth weight, and improving the health status of West Virginia's children. These agencies also recognize the importance of maximizing scarce fiscal resources and the benefit of collaborative efforts in the development of programs that support shared goals. West Virginia's efforts to improve the health status of pregnant women and children have been successful over time as evidenced by broadened medical coverage, streamlined medical eligibility processes, shared government funding for targeted populations, targeted outreach, risk reduction education, and development of comprehensive programs that address both medical and behavioral issues.

Organizational charts for the WV Department of Health and Human Resources, Bureau for Public Health and the Office of Maternal, Child and Family Health are attached.
An attachment is included in this section.

D. Other MCH Capacity

As of May 2010, there are 170 staff positions in West Virginia's Title V agency, the Office of Maternal, Child and Family Health, which consists of: 6 senior management, 74 professionals, 23 medical professionals, 61 clerical, and 6 technicians.

Direct health services and education are provided through the network of community-based entities including private practitioners, school-based health centers, local health departments and independently enrolled practitioners that include: occupational therapy, physical therapy, speech pathology, developmental specialists, etc.

During Fiscal Years 1997 and 1998, two parent advisors were recruited by the Office of Maternal, Child and Family Health, one as a paid employee and the other as a volunteer. Since that time these positions have been maintained and increased to a total of five paid parent advisors called Parent Network Specialists (PNSs). The CSHCN Program has continued funding the PNS system which is administered by the West Virginia University Center for Excellence in Disabilities (WVUCED). The PNSs are parents of children with disabilities who are located in communities

throughout the state. The state is divided into five regions and each PNS is assigned a specific region of responsibility. The PNS also has responsibility to supply resource information and Care Notebooks to each CSHCN participant. The Care Notebooks were developed as a case management tool so that parents could track appointments, medicines and treatments.

In 2009, the Parent Network Specialist continued to offer transition services for young adults. They participated in community health fairs and shared medical and educational transition information with adolescents and young adults. After receiving the training of a licensed counselor, the PNS's have continued to organize parent support groups within their regions.

The West Virginia Developmental Disabilities Council ran an ad in the Charleston, WV newspapers on June 16, 2008 soliciting applications from adults with developmental disabilities and parents of young children with developmental disabilities to participate in the Partners in Policymaking series. The Council stated they were seeking highly motivated men and women who represent different ethnic backgrounds, different geographic regions of the state and a variety of developmental disabilities. The Partners in Policymaking is a leadership training program for self-advocates and parents. Partners learn about current issues and state-of-the-art practices. They also become familiar with the policymaking and legislative processes at the local, state and federal levels. The program teaches competencies necessary for individuals to become advocates who can influence the system of services for people with developmental and other disabilities. Partners attend two-day training sessions eight times a year, from September through May. The program covers the cost of lodging, meals and travel. Additionally, stipends are available for respite care services or personal assistance services.

Also available to WV residents is the Tiger Morton Catastrophic Medical Fund. This fund assists persons with medical expenses who have had a catastrophic medical incident and either are underinsured or uninsured. Referrals to this fund are managed by the Systems Point of Entry staff within OMCFH.

The Parent Network Specialists, in collaboration with the West Virginia University School of Dentistry, conducted surveys to assess dental services for children with special health care needs and evaluate service availability from the parent's perspective. Six hundred and fifty surveys were sent to parents in 30 West Virginia counties. One hundred eighty-three or 28% were completed and returned. The survey objectives were: a) To determine the knowledge base that parents of children with special health care needs have about dental care. b) To determine the most common problems parents of children with special health care needs face when trying to find a dentist. c) To determine if parents of children with special health care needs feel their child is receiving adequate dental care and what improvements are needed.

The study concluded that 65% of parents of children with special health care needs felt their child's needs were being met and that the majority of parents have been educated about preventive dental care for their children. To overcome obstacles, dental health care professionals will need to continue to expand their knowledge about treatment of patients with special needs which is a curriculum component of the WV School of Dentistry and an on-going educational issue among the WV Dental Association.

Meeting the health and psychosocial needs of persons with developmental disabilities are reflected in part as: WV Special Olympics sponsor Camp Tommy, a day camp held annually for the developmentally and physically disabled. The camp is held in the Buckhannon-Upshur High School and is held the third week in July. Approximately 100 campers of all ages participate. A variety of planned programs as well as crafts, sports, games and socialization is provided. The camp received a contribution of $5,000 from the OMCFH.

The CSHCN Program, through the Office of Maternal, Child and Family Health, supports the Mountaineer Spina Bifida Camp held in June for those children up to age 21 with the diagnosis of Spina Bifida or Myelodysplasia. In 2009, the camp celebrated its 24th year of residential camping

where children learn independent self care skills while participating in crafts, fishing, swimming, games, talent shows and a "prom" night. The CSHCN Program provides financial support for transporting equipment and supplies to staff who volunteer as counselors.

Other topics of capacity interest include:
The WV OMCFH has applied for and received the State Systems Development Initiative Grant from HRSA for many years. This Grant has allowed us to increase our data collection and analysis capacity over the years. The SSDI Project is housed within the Division of Research, Evaluation and Planning. The Division has developed a Data Mart that has access to data from all of OMCFH's programs as well as birth records, infant death records and Medicaid eligibility files. This enables the OMCFH to examine and analyze data using multiple data sources.

The Right From The Start Project's data collection system went web-based in May 2007. Previously there were eight regional centers who collected data on eight stand alone computers. Not only did the Project have user and computer problems across the state, but the data was not always complete. It was difficult to report accurate information. The web-based data collection not only saves traveling time to the different sites, but provides more accurate data.

The Division of Research, Evaluation and Planning has access to multiple data sets to be able to match data to evaluate program activities and results that fall under the OMCFH umbrella. These data bases include: birth and infant death files, newborn hearing screening, newborn metabolic screening, childhood lead screening, birth defects, SIDS/SUID, PRAMS, Birth Score (newborn high risk assessment screening), Medicaid eligibility files, FACTS (Families and Children Tracking System), Family Planning, Right From The Start, Early Intervention/Part C and CSHCN.

Brief biographical sketches of the Office Director and the Division Leaders are outlined below:

Anne Amick Williams, RN, BSN, MS-HCA -- OMCFH Interim Director and Director, Division of Perinatal and Women's Health
EDUCATION:
West Virginia University School of Nursing, Bachelor of Science in Nursing, 1982-1986
Graduated Magna Cum Laude
Marshall University Graduate College, Master of Science in Management/Healthcare Administration, 1993-1999

PROFESSIONAL EXPERIENCE:
Director, Division of Perinatal and Women's Health (2006 to Present)
Office of Maternal Child and Family Health
Bureau for Public Health

Director, Family Planning Program (1991 to 2006)
Office of Maternal Child and Family Health
Bureau for Public Health

Clinical Nurse I -- Neonatal Intensive Care (1988 to 1991)
Charleston Area Medical Center -- Women's and Children's Hospital

Clinical Nurse I -- Pediatrics Unit (1986 to 1988)
Charleston Area Medical Center -- Women's and Children's Hospital

Christina Mullins, M.A. Director, Division of Infant, Child and Adolescent Health (including CSHCN)
EDUCATION:
Psychology, MA, Marshall University, 1997
Psychology, BA, Marshall University, 1995

PROFESSIONAL:
Director, Division of Infant Child and Adolescent Health, Bureau for Public Health (2/09 - Present)
Program Director, Breast and Cervical Cancer Screening Program, Bureau for Public Health (2004 - 2009)
Associate Division Director, Division of Tobacco Prevention, Bureau for Public (2002 - 2004)
Associate Program Director, Tobacco Prevention Program, Bureau for Public Health (2000 - 2002)
Program Coordinator, Tobacco Prevention Program, Bureau for Public Health (2000)
Supervised Psychologist, Allied Behavioral Services (1997 - 2000)
Teaching Assistant, Psychology Department, Marshall University (1996 - 1997)

Kathryn G. Cummons, MSW, ACSW--Director, Division of Research, Evaluation, and Planning
EDUCATION:
Master's of Social Work, West Virginia University, Morgantown, WV (1988)
Bachelor's of Social Work, West Virginia University, Morgantown, WV (1974)
Minors in Psychology and Speech
Attendance at a variety of training and educational seminars on a wide array of topics throughout the past 28 years related to employment at the time.

PROFESSIONAL EXPERIENCE:
Director, Research, Evaluation, and Planning, OMCFH, Bureau for Public Health (9/2000 - Present)
Clinical Social Worker, (12/99 - 9/2000)
Comprehensive Psychological Services
Clinical Social Worker, (9/89 - 7/90) and (5/98 - 12/99)
Charleston Area Medical Center
Director of Social Work Services and Discharge Planning (8/90 - 5/98)
Charleston Area Medical Center
Administrator (7/84 - 5/89)
Northern Tier Youth Services
Supervisor (6/81 - 7/84)
Lutheran Youth, and Family Services

E. State Agency Coordination

The Office of Maternal, Child and Family Health has historically contracted with the Title XIX agency for the administration of EPSDT. In addition, there have also been formalized agreements with community agencies for services offered through the Right From The Start Perinatal Program, Family Planning, and Children with Special Health Care Needs. The Office of Maternal, Child and Family Health administers and participates in the coordination of programmatic services funded under Title XIX to prevent duplication of effort, as required by federal regulation 42 CFR sub-section 431.615 (C)(4). The Office of Maternal, Child and Family Health has administrative responsibility for dental and vision care for persons moving from Welfare to Work. These efforts are financed by TANF resources; a copy of the grant agreement may be obtained from the OMCFH. As a component of the Birth to Three/Part C system change initiative, an additional interagency agreement has been finalized with the Bureau for Medical Services, utilizing the unique statutory relationship between Title XIX and Title V, the agreement established the Office of Maternal, Child and Family Health as the sole provider of early intervention services. The Department of Health and Human Resources has contracted with a private agency to serve as a central finance office to coordinate all funding sources for early intervention services, a centralized data system, and claims.

The Office of Maternal, Child and Family Health has in place many systems that contribute to the early identification of persons potentially eligible for services. These population based systems

include birth score (administered by WVU), birth defect registry, newborn metabolic screening, childhood blood lead level screening, and newborn hearing screening. In addition, because we administer the EPSDT Program, children who have conditions that may be debilitating and/or chronic diseases, are referred to the CSHCN Program for further evaluation. This connection with EPSDT, which targets some 200,000 eligible children yearly, provides public health with a vehicle for identifying youngsters with problems, knowing that economically disadvantaged children are at increased risk. OMCFH, in an effort to increase public awareness, routinely participates in health fairs and community events. Our toll free lines, established in 1980, average over 1,000 calls per month. Each caller receives individualized follow-up from our Systems Point of Entry staff to assure referrals and pertinent information related to the request met their need. OMCFH toll free lines always receive accolades. Evaluation materials are on file and available if desired.

One of the strategies the Office of Maternal, Child, and Family Health has applied to ensure the quality of EPSDT services is to partner with others. Partnerships with others can bring additional experience, expertise and resources to bear on improving EPSDT. HealthCheck and WV Birth to Three routinely work in partnership for the early identification of developmental delays in children. Recently, HealthCheck and WV Birth to Three purchased more than four hundred (400) Ages & Stages Questionnaires, Third Edition (ASQ-3™) starter kits after consulting with the WV Chapter of the American Academy of Pediatrics (AAP). HealthCheck Regional Program Specialists will distribute the ASQ-3™ starter kits and provide training to primary care providers (medical homes) throughout the state. WV Birth to Three has planned to incorporate the ASQ-3™ in their initial intake process. Furthermore, HealthCheck and the WV Immunization Program have agreed on a collaborative effort to diminish unnecessary barriers to achieving better immunization rates among our population by promoting the Vaccines for Children (VFC) Program with primary care physicians (medical homes). The VFC Program is an effective means to reduce immunization referrals, which may not be accomplished a significant percentage of the time and, as a consequence, constitute a barrier to achieving the vaccination.

Risk Reduction Through Focus on Family Well-Being (HAPI):
The OMCFH and West Virginia University finalized an agreement for joint implementation of the Risk Reduction Through Focus on Family Well-Being/Helping Appalachian Parents and Infants (HAPI) Project, a Healthy Start grant, in RFTS Region VII. Several providers, including mental health providers and dentists, signed agreements to participate in the program to provide patient services. The services encompass care coordination provided to pregnant women and infants, including a preconception phase, as per the existing RFTS Project. The HAPI Project focuses on helping women become healthier before becoming pregnant, encourages spacing of pregnancies, provides child care services, oral health care reimbursement, transportation assistance to doctor appointments and payment for mental health services. Curriculum for patient education was developed by WVU. OMCFH, as the subcontractor, acts as the fiscal agent for HAPI. Billing procedures have been developed by OMCFH and patient services invoices are processed by the state on behalf of the grantee, WVU.

The OMCFH and WVU continue to collaborate to provide services to high-risk pregnant women and infants through the Healthy Start, HAPI Project. Initially started in four West Virginia counties, the HAPI Project has expanded to include eight counties, with service components in areas of: oral health services; substance abuse screening and referral; and outreach services utilizing former consumers.

The long-term goal of the Project is to decrease the incidence of low birth weight infants born in West Virginia by reducing recurrent low birth weight. It is hoped that resulting data may also show that there is a significant benefit of cost savings through the risk reduction plan for at risk families. Hopefully from this data, RFTS can justify the benefit in expanding the current case management program to include the risk reduction plan for families and allow implementation of a longer period of eligibility for case management to assist at-risk families.

Prenatal Risk Screening:

Concerns about maternal and infant health were the catalysts for convening the WV Perinatal Partnership in 2006. The resulting "Blueprint to Improve West Virginia Perinatal Health," contained multiple recommendations and action steps to make needed system improvements.

Policy recommendation number one was to create a coordinated statewide perinatal system including the request that the state identify a maternal risk scoring instrument to be used universally by all obstetrical medical providers and all payers.

Comprehensive risk screening enables the prenatal care provider to determine whether the woman, the fetus, or the infant are at increased risk and provides the basis for further assessment and intervention. Risk factors are characteristics that indicate a higher probability of adverse outcome and help guide the action by the woman, social supports, and the medical provider.

The Perinatal Partnership Universal Risk Screening Committee believed that early prenatal care, with an emphasis on risk screening at the first prenatal visit and appropriate follow-up, was critical. In WV, the most likely adverse pregnancy outcome is preterm labor and/or low birthweight. A review of health data and key informant survey responses confirmed that smoking during pregnancy plays a huge role in poor pregnancy outcomes.

Since the 1980s, West Virginia has screened low income, government-sponsored women for adverse outcomes, and although the screening instrument has changed numerous times over the last 25 years, the use of the information to prevent or treat conditions associated with poor pregnancy outcomes has remained the same. Low income pregnant women who receive government-sponsored health care are routinely screened using the Prenatal Risk Screening Instrument (PRSI), developed by WVU, Department of Ob/Gyn. The risk scoring forms completed by the pregnant woman's medical practitioner trigger a referral to the RFTS Project. The RFTS provider network are community-based licensed social workers and nurses who provide individual care planning, taking into account medical and psychosocial patient risks. The RFTS workforce has responsibility to arrange for community resource referral and consultation, as well as offering in-home educational services designed to affect patient behavior. The challenge is, while the screening has enjoyed widespread use, it is not used for pregnant women who have commercial coverage, and even if the PRSI were completed, a pregnant woman who is not in government-sponsored care is not eligible to receive the in-home care coordination offered by the RFTS network. Further, participation in RFTS, is strictly voluntary, although all pregnant Medicaid beneficiaries and Title V beneficiaries are eligible for the program.

While other insurers support prenatal risk screening for their beneficiaries, the intensity and the type of management offered in response to the probability of adverse patient outcome varies by carrier. There is no insurer that provides the care management equivalent of RFTS, i.e., home visits and one-on-one education.

A survey of West Virginia medical obstetrical practitioners was completed by OMCFH to determine their current risk screening practices including the instrument used, and the PRSI was most often cited as the tool used. Out of 120 surveys returned, 40% reported regular use of the PRSI, 14% used an ACOG tool, 4% used the POPRAS, 14% used an in-house tool and 28% were not using a risk assessment form. The PRSI includes both medical history and psychosocial information to assess risk. Screening differs from assessment in that screening only identifies those most likely to be at increased risk and should result in further assessment to determine intervention and service need. In short, risk screening is the beginning of the process.

The Universal Risk Screening Committee recommended (1) the PRSI, a screening instrument unique to West Virginia and not copyrighted, can be used statewide without significant cost investment; (2) the PRSI is one page and not burdensome for the medical practitioner or other office staff; (3) the PRSI, as evidenced by the survey, already enjoys widespread acceptance and use; (4) because the form is homegrown, there is the option to modify it; (5) modifications to the

form can, in time, be a result of data gathering, analysis and evaluation to better reflect West Virginia's need and patient risks.

Legislation passed during the 2009 session as Senate Bill 307, created the Maternal Screening Act, relating to development of a maternal risk assessment advisory council; providing for legislative findings; setting forth responsibilities of the advisory council; providing for legislative rule-making authority within the Department of Health and Human Resources to develop a uniform maternal risk screening tool; providing for applicability of the screening tool once developed; and providing confidentiality of the tool.

The bill stated the "Legislature finds that there is a need for a more comprehensive and uniform approach to any screening conducted by physicians and midwives to discover at-risk and high-risk pregnancies. A uniform approach would simplify the process, standardize the procedure and better identify those pregnancies that need more in-depth care and monitoring. Additionally, a uniform application would provide better and more measurable data regarding at-risk and high-risk pregnancies. This would allow public health officials to gain a better understanding of those conditions that are most frequently observed and to develop methodology to address those concerns." The bill established an advisory council within the WV DHHR, Office of Maternal, Child and Family Health to provide the Office with assistance in the development of a uniform maternal risk screening tool. Following implementation in January 2011, all health care providers offering maternity services will be required to utilize the tool in their examinations of any pregnant woman, maintain confidentiality and notify the woman of any high-risk condition which they identify along with any necessary referral.

West Virginia's Office of Maternal, Child and Family Health is known for its positive partnerships with the medical community, the University Affiliated Programs, the State Department of Education, and the March of Dimes Chapter, among others. These partnerships have resulted in shared initiatives. One initiative is the folic acid campaign, a national March of Dimes assignment, used in West Virginia to advocate for the distribution of this supplement preconceptually to reduce the incidence of neural tube defects. Another initiative made possible was the Richard Windsor smoking cessation program in partnership with the Office of Epidemiology and Health Promotion, who contributed tobacco funds for the purchase of CO monitors for the 233 care coordinators for use with pregnant women statewide. A recent initiative is school enterer screening using the EPSDT (HealthCheck) protocol, called Kids First. The objectives of the initiative are: to establish a medical home for the child, to allow school systems to focus on providing needed services for children with identified deficits, to assist families in finding treatment resources, and to promote healthy lifestyle activities. The focus of the screening will be on the domains of oral health, vision, hearing, speech and language, and behavior/development. Kids First is an example of high-level collaboration in government. Three Cabinet level agencies, the Department of Education, the Department of Health and Human Resources and the Department of Administration, are working closely together to bring this project to the families of West Virginia. All insurers agreed to pay for the services. Another initiative is the West Virginia Perinatal Wellness Partnership that includes stakeholders from across the state. Stakeholders include obstetrical and neonatal physicians, Medicaid, private insurance providers, OMCFH, Vital Statistics staff, the Hospital Association and the March of Dimes to mention a few. The 2007 work plan of the the Partnership includes the following: 1. Establish a statewide perinatal transport system, 2. Identify and address obstetrical provider shortage areas, 3. Address the lack of oral health care in pregnancy, 4. Identify costly medical procedures associated with poor birth outcomes, 5. Develop an approach to identifying and treating drug use during pregnancy, 6. Promote perinatal worksite wellness, and 7. Support and promote breastfeeding.

The Birth to Three/Part C Program partners with a multitude of agencies to assist with child find efforts and to ensure needed services are arranged. WV Birth to Three has institutionalized a variety of strategies for the early identification of infants and toddlers with developmental delay or significant risk factors. WV Birth to Three's interagency agreements with Title V, CHIP, Bureau for Children and Families, Head Start, and Medicaid assist in the early identification and referral of

potentially eligible children. West Virginia finds that coordination with primary health care providers and other community partners is important to assure that children potentially in need of early intervention services are identified as early as possible.

WV Birth to Three continues coordination with Title V/CSHCN, Newborn Hearing, and Right From The Start programs to assure that infants failing the newborn hearing screen receive diagnostics, and referral to Part C and Ski *Hi when hearing loss is confirmed. The Birth Score universal newborn screening, conducted on all children born in West Virginia, identifies infants who are born with conditions that may make them at risk for developmental delay. Referrals are made directly to the appropriate Birth to Three Regional Administrative Unit (RAU). Public awareness and child find activities are conducted collaboratively with interagency partners, including Part B preschool, Child Care and Head Start. Examples of this collaboration include the publication and distribution of a quarterly magazine, annual calendars, and developmental wheels to county schools, physicians, Family Resource Networks, medical clinics, early childhood providers, and higher education faculty. The publications include information about how to make a referral to Part C, Part B, Head Start and/or Child Care. The WV Birth to Three Public Information Coordinator has worked closely with WV CHIP to develop parent educational and child find materials, to be distributed collaboratively. The WV Birth to Three Public Information Coordinator has participated in faith based planning initiatives coordinated through WV CHIP to provide information about WV Birth to Three as a resource for families.

Child find strategies have also included coordination with the Right From The Start and HealthCheck Programs coordinated through the Office of Maternal, Child and Family Health. Local Right From The Start personnel who work directly with high risk mothers and infants are able to identify those children who may be in need of early intervention services. Program Specialists within the HealthCheck Program, in their work with physicians, are able to provide information about the criteria and requirements, and importance of identifying children who may be in need of early intervention services. Recent policy direction by the AAP to its members encouraging early screening for developmental delays and subsequent referrel to Part C have also contributed to increases in the number of children served by the Program.

WV Birth to Three staff have coordinated with the Bureau for Children and Families, Child Protective Services, in the development of procedures to assure the referral of children who have experienced substantiated abuse and/or neglect. Training is provided to WV Birth to Three service coordinators and practitioners related to the requirements and coordination with Child Protective Services and Foster Care, as required by the Federal Child Abuse and Protection Act (CAPTA).

The prevalence of Autism Spectrum Disorder (ASD) is approximately 1 in every 100 American children. In an effort to secure more commitment to expanding access to services such as early identification, diagnosis, early intervention, family support, etc. in West Virginia, the Autism Training Center at Marshall University received a funding increase of 1 million dollars for FY 09, making a total appropriation of $2,075,739 per year from the West Virginia Legislature.

In addition, the State Legislature, in 2008, introduced a bill to require health insurers to provide full coverage of prevention, detection, diagnosis and treatment of Autism Spectrum Disorder. The legislation did not leave Committee, in spite of much public advocacy during Disability Awareness Day at the State Legislature. Obviously this legislation was of interest to OMCFH, since the early intervention, Part C Program, called Birth to Three, serves many toddlers with autism.

Agency Partners include: (list not all inclusive)
-400+ medical contracts with private physicians, community health centers, local health departments and hospital based clinics for the provision of EPSDT.
-Birth to Three/Part C provides grants to local entities to act as system point of entry for eligibles.
-Memorandum of Understanding with WIC and SSA for referrals as referenced earlier.
-Working agreement with the Office of Social Services (Title IVB) for children in state custody to

receive enhanced health screens through OMCFH's medical provider networks.
-Working agreement with the Office of Social Services for interagency training for professionals and para-professionals serving young children-including use of assistive technology and understanding ADA.
-Agreements with WVU for genetic services and administration of the Birth Score Project.
-Agreements statewide with 150+ private physicians, community health centers and local health departments for Title X family planning services.
-Agreements serving 300+ sites statewide for breast and cervical cancer screening program services.
-Agreements with 8 regional lead agencies to locally administer the Right From The Start Project and subsequent agreements with multiple agencies to provide direct services to perinatal populations who employ more than 165 licensed social workers and nurses, 83 Designated Care Coordination Agencies, 76 OB providers (contracted)
-March of Dimes
-Developmental Disabilities Council
-Medical Advisories for all programs and projects
-University Center for Excellence in Disabilities
-Interagency Coordinating Council for Birth to Three/PartC (state statute established).
-Department of Education/Healthy Schools
-Starting Point Centers (Early Childhood Initiative, initially funded with Carnegie Foundation monies)
-Head Start
-Cancer Coalition (established state statute)
-Membership, West Virginia Association of Community Health Centers
-WV Commission for the Deaf and Hard of Hearing (Board Member)
-Division of Perinatal and Women's Health Medical Advisory Committee
-Children's Mental Health Collaborative
-WVU Healthy Start HAPI Project
-American Lung Association
-WV Division of Tobacco Prevention
-All Offices within WV DHHR

The West Virginia University School of Medicine has been recognized as one of the top ten schools of medicine in the country for rural medicine. WVU made the top ten list for the first time in U.S. News & World Report's 2009 edition of "America's Best Graduate Schools." Rankings are based on ratings by medical school deans and senior faculty in the nation's 125 accredited medical schools and 20 accredited schools of osteopathic medicine. School of Medicine students learn and care for patients in rural areas of West Virginia as part of the requirements for graduation. They work in partnership with rural communities and other health care providers in rural clinics across the state. Rural health training at WVU is about education and community service. Forty-eight percent of WVU School of Medicine graduates choose to practice in primary care areas, such as family medicine, internal medicine, emergency medicine, and pediatrics.

F. Health Systems Capacity Indicators

Introduction

Medicaid serves a large portion of the population within the state, including women, infants and children. Approximately 60% of all deliveries of infants are paid for by Medicaid. Within the capacity indicators there is a definite variation in the Medicaid versus non-Medicaid population. The family income eligibility for CHIP was expanded and now covers children in the state who were otherwise uninsured.

The Division of Research, Evaluation and Planning within the OMCFH has received a grant from HRSA for State Systems Development Initiatives since 1996. The Research Division has used these funds to increase capacity and access data files throughout the Bureau and beyond. The OMCFH Research Division has access to both birth and death files on a regular basis from Vital Statistics, birth defects data, childhood lead screening data, Medicaid eligibility files, newborn metabolic screening from the State Laboratory, high risk and hearing screening data collected on the Birth Score card through West Virginia University, CSHCN data, and the states's perinatal program data.

Barriers

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	111.2	164.0	108.9	113.8	108.0
Numerator	1132	1670	1109	1159	1100
Denominator	101805	101805	101805	101805	101805
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
based upon 2008 Hospital Discharge Data, HCA

Notes - 2008
2008 Hospital Discharge Data, HCA

Notes - 2007
2007 Hospital Discharge Data, HCA

Narrative:
Approximately 12% or 42,000 West Virginians under the age of 18 have at some point been diagnosed with asthma by a health care professional.

WV has one of the highest smoking rates nationally and second hand smoke is a known irritant for asthma. Appropriately so, tobacco monies are also being used to address environmental factors that increase the risk of developing asthma or exacerbate the disease. Although the OMCFH is not the home of the Asthma Initiative, since it is a disease that affects both children and adults, the OMCFH has a role in prevention via education of parents and children, plus a direct clinical care role which includes: 1) addressing maternal smoking during pregnancy and/or early infancy, and 2) provision of asthma therapy for children to include maintaining pulmonary function, normal activity levels, minimizing emergency room visits and hospitalization, and making available medication to control persistent asthma and "quick relief" medication to treat acute symptoms.

The West Virginia Asthma Coalition consists of members from public health offices as well as community physicians and other interested agencies. The Coalition's role is one of prevention

through education, establishing disease reporting parameters and mechanisms enabling tracking of incidence levels, advocacy for inclusion of benefit coverage across all payors for those affected by the disease, and payment for screening and prevention activities. There also remains the responsibility to assure screening, treatment, etc., is available and accessible to all, an assignment which exceeds the scope of health care financing available to OMCFH.

The West Virginia Department of Education, in collaboration with the West Virginia Asthma Coalition, developed a survey for school administration to determine the educational needs of staff. Responses to the survey identified the need for school personnel education directed at emergency care of the child, asthma inhaler legislation affecting in-school use, exercise and asthma, and managing students with asthma.

The WV Bureau for Pubic Health's Asthma Education and Prevention Program (WV-AEPP) , funded by CDC since 2001, maintains an asthma surveillance system, promotes statewide partnerships, and implements interventions to reduce the burden of asthma in WV. As a member of the Centers for Disease Control and Prevention's National Asthma Control Program, WV-AEPP has a priority goal of decreasing hospitalizations due to asthma complications.

The Asthma Education and Prevention Program distributes quarterly newsletters to individuals, community organizations, and medical practice sites, discussing management, treatment methods, and the harmful effects of smoking.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	95.0	98.0	99.3	97.1	97.4
Numerator	11685	13101	13808	13431	13752
Denominator	12300	13368	13905	13829	14114
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Fiscal Year 2009 - CMS - 416

Notes - 2008
Fiscal Year 2008 - CMS - 416

Narrative:
The OMCFH administers the mandated Medicaid EPSDT Program (known in West Virginia as HealthCheck). The HealthCheck Program educates families who receive Medicaid about preventive health care for their children and encourages their participation in the HealthCheck Program while ensuring the following: 1) children are screened/re-screened according to periodicity tables established by the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition.; 2) medical problems identified by examination are treated/referred; and 3) children/families receive transportation

assistance and help with appointment scheduling. In WV, in 2009, 97% of children under the age of one who receive Medicaid, received at least one initial or periodic screening, an increase of 0.4% from 2008. The HealthCheck Program focuses on equipping Medicaid providers with the necessary tools and knowledge to carry out EPSDT screening services. As part of the Governor's Kids First Initiative all school enterers are required to receive a health screen using EPSDT protocol, regardless of insurance carrier.

Since 2007, WVCHIP has continued their partnership with the Office of Maternal, Child, and Family Health's Division of Infant, Child and Adolescent Health, to promote full periodic and comprehensive well child visits recommended by AAP. Health messages focusing on vision, dental, development, and hearing screenings appreared in Child Care Provider Quarterly Magazine. Through this partnership, WVCHIP identified the "HealthCheck" form as the standard form providers are to use in all well-child exam visits, and this occurred prior to the implementation of Kids First.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	96.1	100.0	100.0	94.1	100.0
Numerator	99	14	16	16	18
Denominator	103	14	16	17	18
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
CHIP 2009 Annual Report, date ending June 30, 2009. Continuous 12 month enrolled children less than or equal to 15 months.

Notes - 2008
CHIP 2008 Annual Report, date ending June 30, 2008. Continuously enrolled children less than or equal to 15 months.

Notes - 2007
2007 CHIP Annual Report - data for fiscal year ended June 30, 2007. Continuously enrolled children less than or equal to 15 months.

Narrative:
The bipartisan Rockefeller-Kennedy-Snowe CHIP Reauthorization Act of 2007 (S.1224) provided significant new federal resources for children's health coverage that enables states to substantially expand the number of children in this country who have health care. The legislation assures states a stable and sufficient source of financing to cover uninsured children. Because of this, West Virginia's Governor, Joe Manchin lll, signed into legislation, during the 2007 session, CHIP eligibility expansion up to 300 percent of the FPL. A phase-in eligibility of up to 220 percent of the FPL began July 1, 2007. In July of 2008, the eligibility raised to 250% of the FPL.

Not many infants, under the age of one, in WV are eligible for CHIP. Most infants under age one are insured by Medicaid (eligible at or below 150% FPL) or private insurance.

The following projects have been implemented in West Virginia:
-WVCHIP continued partnership efforts to promote healthy lifestyles with the West Virginia Immunization Network, Action for Healthy Kids Coalition, West Virginia Asthma Coalition, and the Medical Advisory Council.
-In 2006-2007, WVCHIP continued partnership with OMCFH's Infant, Child and Adolescent Health to promote full periodic and comprehensive well child visits recommended by pediatricians in a HealthCheck campaign. Health messages focusing on vision, dental, development, and hearing screenings appeared in Child Care Provider Quarterly Magazine. Through this partnership, WVCHIP identified the HealthCheck form as the standard form providers use in all well-child exam visits.
-The West Virginia Immunization Network, the state's Immunization Program and WVCHIP continue working on strategies to implement an immunization campaign targeting adolescents. WVCHIP provided matching funds to Raleigh County to implement the "Take Your Best Shot" adolescent campaign, which began in October, 2007.
-WVCHIP provided flyers and ABC's of Baby Care to include in Day One Packets for distribution to all new mothers at participating West Virginia hospitals.
-WVCHIP materials were included in the state's Immunization Program packets to new mothers through the Right From The Start Coordinators.

WVCHIP continues to collaborate with community partners identified in the State Plan, however, as enrollment has stabilized, efforts to promote public awareness of the program have shifted from an enrollment focus to one of promoting child health awareness and prevention messaging on topics such as childhood health screening, child development, immunizations, and the importance of a medical home.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	81.5	83.0	75.9	74.3	75.1
Numerator	16982	17375	16245	15977	16000
Denominator	20834	20931	21407	21492	21299
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
based upon 2008 Vital Statistics and preliminary 2009 births calculated by 1st trimester with 11+ visits, 2nd trimester wtih 6+ visits and 3rd trimester with 1+ visits

Notes - 2008
2008 Vital Statistics - calculated by 1st trimester with 11+ visits, 2nd trimester wtih 6+ visits and 3rd trimester with 1+ visits

Notes - 2007
2007 Vital Statistics - calculated by 1st trimester with 11+ visits, 2nd trimester wtih 6+ visits and 3rd trimester with 1+ visits

Narrative:
According to 2008 WV Vital Statistics, 5.8% of women had 1-5 prenatal care visits, 27.9% of women had 6-10 prenatal care visits, 53.7% had 11-15 prenatal care visits and 11.1% had 16 or greater prenatal care visits. Of women with known prenatal care 80.8% of women began prenatal care in the first trimester, 15.5% began in the second trimester and 3.0% began prenatal care in the third trimester while 0.6% of women received no prenatal care.

Availability of prenatal care providers continues to be problematic. Also, the only board-certified perinatal specialists in WV are located in Charleston, Huntington, and Morgantown, where the tertiary care hospitals are located. Women and babies needing the services of high-risk specialists often have to travel long distances for an appointment. Many do not keep their appointment because of the long distances on difficult WV roads. Telemedicine is being expanded to bring expertise to patients and community-based physicians in rural areas, saving transportation cost and time. In addition, community-based physicians would receive valued support. Telemedicine also gives health care providers access to continuing education lectures that are given at medical schools.

Improvement in the health of West Virginia's perinatal population is a result of a carefully crafted, highly-interdependent partnership. Tertiary care centers, primary care centers, local health departments, private practitioners and community agencies have worked with the OMCFH for more than thirty years to improve the health and well-being of the state's people. In conjunction with its medical advisory boards, OMCFH has designed a system that offers early and accessible health care to low income, medically indigent and underinsured women and children. A successful perinatal care system requires adequately trained professionals to provide complete reproductive health services that include family planning, preconceptual counseling, prenatal care, delivery, newborn care and care for the woman in the postpartum period.

Early preventive prenatal care and education are recognized as the most effective and cost effective ways to improve pregnancy outcomes. Currently, RFTS provides comprehensive perinatal services to low-income women up to sixty days postpartum and care coordination for Medicaid eligible infants up to one year of age. Right From The Start also provides direct financial assistance for obstetrical care for West Virginia pregnant women who are uninsured or underinsured and are above income guidelines for Medicaid coverage. These pregnant women may qualify for assistance for prenatal care if they are a West Virginia resident, have income between 150%-185% of the FPL, are a pregnant teen age nineteen or under, or are a non-citizen. Under this Title V funded service, women who have no funding source for prenatal care coverage or have not yet been approved for coverage can receive assistance for payment of their first visit.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	98.9	98.5	98.5	98.9	97.9
Numerator	212200	207060	204413	204502	208963
Denominator	214500	210181	207606	206729	213390
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
CMS-416 Annual Report Fiscal Year 2009
(total receiving one initial screen + corrective treatment + any dental services)

Notes - 2008
CMS-416 Annual Report Fiscal Year 2008

Narrative:
HealthCheck is West Virginia's name for the mandated pediatric Medicaid program, Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Over 200,000 Medicaid-approved children in West Virginia have been eligible to participate in the HealthCheck Program for the past three years. EPSDT's promise to children eligible for Medicaid is the provision of screening services and treatment of all medical conditions discovered during the exams.

HealthCheck Program Specialists are assigned to geographical regions to educate, orient and provide ongoing technical assistance to EPSDT providers and have been especially active in recruiting additional primary care providers for underserved areas. This workforce has been successful in increasing the overall number of EPSDT providers over the past several years and routinely provides EPSDT orientation for HMO providers serving Medicaid enrolled children. These activities have been helpful in establishing the desired eligible child to provider ratio; however, the influx of CHIP eligibles has presented an additional challenge since the WV medical community is presently at capacity. The Program provides ongoing staff development to enhance skills needed to better market the EPSDT Program to both providers and families. Program Specialists, who recruit, train, and provide technical assistance to participating medical providers, have also been active in working with local school systems to increase the number of school-based clinics and on site EPSDT evaluations. The number of students using school-based health centers (SBHC) has steadily increased over the past few years. The School-Based Health Center Initiative's goal is to develop a coordinated system of health care for children that increases access to primary and preventive care, especially for students who are uninsured, who lack a medical home, or who are at risk for health problems.

The EPSDT Program, administered by the Office of Maternal, Child and Family Health, provides dedicated outreach to Medicaid eligible children and youth not enrolled in a Managed Care Organization in order to encourage participation and provides technical assistance support to school-based health centers and participating physicians to assure EPSDT compliance. The OMCFH administers the EPSDT Program, and uses the outreach requirement of the federal legislation to encourage families with children to participate in routine, primary preventive care.

The EPSDT Program also works closely with the Bureau for Children and Families in assuring that all children in state custody receive an EPSDT screen within three days of placement into DHHR custody.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	48.0	54.0	54.5	56.0	57.9
Numerator	19800	22339	22398	22778	24237
Denominator	41244	41353	41073	40691	41838
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Fiscal Year 2009 - CMS - 416

Notes - 2008
Fiscal Year 2008 - CMS - 416

Notes - 2007
Fiscal year 2007 CMS 416

Narrative:
The Children's Dentistry Project (CDP) is a component of the Oral Health Program within the Division of Infant, Child and Adolescent Health housed within the OMCFH. In WV, Medicaid child beneficiaries have financial access to dental services, yet most do not routinely seek care. While State Medicaid Programs are required by federal law to provide dental services to eligible children, enrollees' access to dental care is poor. Failure to keep appointments is the reason cited by dentists as the primary reason they do not serve the Medicaid population, thus limiting access. It is clear that public health must facilitate opportunities for youth to access dental care by educating children, youth, and their parents about the importance of oral health.

The great majority of dental care in West Virginia and across the country is delivered by private practicing dentists, so participation is key to improving access for publicly-sponsored patients. Approximately 2/3 of dentists in West Virginia have agreed to accept Medicaid and CHIP beneficiaries. They, like dentists across the country, cite three primary reasons for their low participation in state Medicaid programs: low reimbursement rates, burdensome administrative requirements and problematic patient behaviors.

In 2009, OMCFH convened an Oral Health Advisory to study policy and procedures necessary to improve oral health access and utilization. In March 2010, this advisory completed its first strategic plan to address oral health in the context of a public health issue.

The CDP currently has 27 contracts with local health departments, primary care centers and individuals to offer oral health education to students in public schools in all 55 West Virginia counties. Educators offer information about dental hygiene, the need for preventive dental visits, and the dangers of tobacco use. The CDP, in partnership with county school systems, Head Start agencies, and other community children's programs, work together to offer a sealant and fluoride rinse program within schools.

While public water systems are primarily floridated, there are significant numbers of West Virginians who do not have a fluoridated water supply. Fluoridation equipment is not expensive and supplies are no more than $3 per customer per year. The savings in future dental caries is 5 to 6 times that amount. The CDP has been working with the Office of Environmental Health to generate increased interest for this issue.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	15.2	16.6	10.7	9.5	8.1
Numerator	1049	1079	987	879	748
Denominator	6901	6489	9196	9233	9233
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
numerator is children under 18 - receiving CSHCN services

Notes - 2008
numerator is children under 18 - receiving CSHCN services

Narrative:
The CSHCN Program advances the health and well-being of children and youth with chronic health care needs, including cleft lip and palate, neurologic, and cardiac problems. The goal is to facilitate early care, offer consultation and clinical intervention, care management and planning, and support the family and community in the care of children with special health care needs. The Program provides care coordination services to children, age birth to 21, with a variety of payers such as Medicaid, CHIP, PEIA, Blue Cross Blue Shield and other insurance. Components of the Program include: 1) assessment of children with special health care needs and enrollment in clinical care or referral to alternative sources as medically indicated; 2) participate in development of multidisciplinary treatment plans; 3) act as resource support to increase awareness of and need for primary, preventive health care; 4) establish linkages with sub-specialty physicians, therapists and other providers; 5) CSHCN staff provide care management, including developing and monitoring treatment plans, assisting families with scheduling and transportation, and referral to other community services; and 6) adolescent/adult transition planning, including referral for work/training.

The CSHCN Program provides medical and care coordination services for children birth to 21 years of age. In 2009, 742 children/youth received services in 28 specialty care clinics throughout the state.

There were 748 SSI recipients under 18 years of age who also received CSHCN services. As of December 2009 there were 9,233 children in WV under the age of 18 receiving SSI benefits indicating that the CSHCN Program served 8.2% of WV children under the age of 18 who received SSI benefits. Not all conditions that qualify children for SSI are eligible for participation in the CSHCN Program. For example, CSHCN does not have capacity, professionally or fiscally, to care for autism, serious emotional disorders, etc., conditions which often trigger SSI eligibility.

In 2008, 1,368 clinic visits took place which included both enrolled clients and those in pending status receiving a first time evaluation in 28 specialty clinics throughout the state. There were 1,630 enrolled clients in the CSHCN Program by the end of 2009.

The CSHCN Program is committed to assisting families with SSI applications and expediting the SSA/Disability Determination process. To meet this goal the CSHCN Program continues to partner with the SSI Disability Determination Unit to share medical information on children seeking SSI.

In an effort to expand services to all children with special health care needs in WV, the CSHCN Program provided the nursing or social service component to 173 community clinics held in physician's offices or in local health care facilities in 2009. Included were clinics held in six locations throughout the state with Dr. Hummel the state's only geneticist.

There were 3,181 resources/referrals provided in 2009.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	10	8	9.5

Narrative:
West Virginia has struggled with the incidence of low birth weight infants. Birth weight is the single most important predictor of survival. Risk factors for preterm birth and low birth weight include: previous preterm and/or low birth weight birth, multiple births, smoking, unplanned pregnancy, infections, poor nutrition, lack of access to adequate and early prenatal care, harmful substance abuse, and domestic violence.

The RFTS Project provides in-home care coordination to a high risk population of pregnant women and infants. 2009 data show the average birth weight for an infant born to Project participants was 7.07 pounds, an increase from 6.95 pounds in 2008. The high incidence of low birth weight is concentrated in a small number of counties. Activities to address this include RFTS follow-up to discuss nutrition during pregnancy, enrollment in WIC, and education on the importance of adequate and early prenatal care and smoking cessation.

Warning signs of preterm labor are printed on brightly colored labels and shipped to RFTS Maternity Services enrolled obstetrical providers along with each order of prenatal vitamins from Materials Management. These vitamins are supplied at no charge to enrolled providers and are dispensed to pregnant women who are ineligible for Medicaid coverage but are eligible for assistance with funding of their obstetrical care through RFTS Maternity Services.

The WV Family Planning Program supplied colorful, laminated posters to all RFTS DCCs entitled "Contraceptive Choices" which help to better educate women on family planning options. The RFTS Project will continue to refer women to the WV Family Planning provider network for preconception counseling and for postpartum family planning services. The Family Planning provider network refers families for specialized genetics counseling/testing as indicated.

The RFTS Project works collaboratively with WV OB providers, March of Dimes, WIC, American Lung Association, WV Perinatal Partnership, and many other groups to educate women on the health consequences of premature births. The OMCFH remains dedicated to reducing the number of babies born early and/or too small.

The RFTS Project provides intensive education for women who participate in services, and continues to be the statewide network through which the March of Dimes provides education, literature, information on prematurity awareness to West Virginia residents and medical providers. March of Dimes programs focus on education about the signs of preterm labor and research into the causes. The current campaign for the West Virginia March of Dimes is prematurity awareness.

The OMCFH uses outcomes from the Perinatal Partnership to plan future risk reduction activities for WV pregnant women. RFTS Project RCCs and DCCs are participating in specific workgroups and planning activities to address issues identified as risk reduction activities.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	payment source from birth certificate	9	5	7.7

Narrative:
Vital Statistics data for 2008 show over one out of six (18.7%) infant deaths in 2008 was due to SIDS. Approximately one in four (23.5%) was the result of congenital malformations, while 41% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birthweight (7.2%). The number of neonatal deaths dropped by seven, from 103 in 2007 to 96 in 2008; the neonatal death rate also decreased, from 4.7 deaths among infants under 28 days per 1,000 live births in 2007 to 4.5 in 2008. Neonatal deaths comprised 57.8% of all WV resident infant deaths in 2008 compared with 63.2% in 2007. The overall infant mortality rate for West Virginia in 2007 was 7.4 and 7.7 in 2008 deaths per 1,000 live births whereas the overall infant mortality rate for the United States in 2007 (latest data available) was 6.7 per 1,000 live births.

According to WV SIDS Project data for 2008, 30 infant deaths were listed as Sudden Unexplained Infant Deaths (SUID). The majority of the infants (23) were between one to five months of age, 27 involved co-sleeping, 27 involved maternal smoking during pregnancy and 23 involved hazardous bedding.

RFTS DCCs reminded enrolled families of the importance of providing anticipatory guidance to participating families on the risks of co-sleeping, the importance of placing infants on their back to sleep, the importance of smoking cessation during pregnancy and the importance of creating a smoke free environment for all infants. DCCs have been instructed on how to document this information and all other on-site observation in client files.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-**	**ALL**

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				**MEDICAID**	
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	other	76.9	90.9	82.7

Notes - 2011
2007 PRAMS data

Narrative:
Although WV has serious perinatal health care issues such as smoking among pregnant women, premature deliveries, and low birth weight infants, OMCFH has woven together a patchwork of funding streams to create a system of health care for women, infants and children. OMCFH maintains strong partnerships across the state with the medical community and private sectors, as well as community health centers and local health departments, in an effort to assure continued access to care.

When the Perinatal Partnership published the Reports on the Blueprint to Improve West Virginia Perinatal Health in 2007, the only board-certified perinatal specialists in WV were located in Charleston, Huntington, and Morgantown. Women and babies needing the services of high-risk specialists often have to travel long distances for them. Many do not keep appointments because of the long distances on difficult WV roads.

On February 18, 2010, the WV Perinatal Partnership officially announced the launching of the Perinatal Connect to Care Project. The project is funded by a Rural Utilities Service Grant from the U.S. Department of Agriculture and matching funds from eighteen partnering WV hospitals and community health centers. The project will provide telemedicine equipment and training necessary to link fifteen rural health facilities (pregnant women and infants, physicians, nurse practitioners, nurses) with the medical specialist in hospitals that care for high risk pregnant women and infants (perinatologists). The live telecommunications will allow high risk pregnant women and infants, and their health care providers to obtain important medical advice without leaving their own communities and traveling far distances. Connect to Care will also allow for medical and nursing education at the rural sites and access for obstetrical referrals.

For the first time, fifteen rural healthcare sites will have access to specialized medical consultation via live telemedicine with the three WV hospitals providing high risk prenatal and newborn care. Approximately 255,534 women of child bearing age in fifteen rural WV communities will have easier access to specialized maternity and newborn care, eliminating the need to travel for far distances. 353,250 rural county residents will realize additional benefits from this project through access to the medical videoconferencing equipment provided in their local areas.

Since the RFTS Project was first initiated in 1989, access to first trimester prenatal care has shown improvement from 69.7% to 80.8% in 2008.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05	YEAR	DATA SOURCE	POPULATION

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State			**MEDICAID**	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	other	70	80	74.4

Notes - 2011
Vital Statistics visits per month

Narrative:
According to 2008 WV Vital Statistics, 28.5% of women had six to ten prenatal care visits, 54.8% had eleven to fifteen prenatal care visits and 11.2% had sixteen or greater prenatal care visits.

Ensuring access to health care for low income women and children has been an ongoing concern for state and federal officials. The Bureau for Medical Services (Medicaid) and Office of Maternal, Child and Family Health (OMCFH) have worked collaboratively to develop special initiatives that extend support services to women and infants at risk of adverse health outcomes. This partnership has not only expanded the state's capacity to finance health care for women and children, but has also strengthened the delivery of care by establishing care protocols, recruiting medical providers and developing supportive services such as case management and nutrition counseling which contribute to improved patient well being.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	250

Narrative:
As of June 30, 2009, 12,966 infants under the age of one year were covered under Medicaid and 120 infants under the age of one were covered by WVCHIP. This population had almost a 100% rate of having a primary care visit within this first year of life.

West Virginia Governor, Joe Manchin lll, signed into legislation during the 2007, expansion of WVCHIP eligibility of up to 300 percent of the FPL. A phase-in eligibility of up to 220 percent of the FPL began July 1, 2007. On July 1, 2008, eligibility for CHIP was raised to 250% of the FPL.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 12) (Age range 13 to 18)	2009	 133 100 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 12) (Age range 13 to 18)	2009	 250 250 250

Narrative:
WVCHIP has worked closely with all partners and entities identified in its State Plan, however, the West Virginia Healthy Kids and Families Coalition has played a pivotal role in working with community based partners to reach uninsured children across the state of West Virginia. This is the Coalition's final year as a grant recipient of the Robert Wood Johnson Foundation's "Covering Kids Project." This year's collaborations included media campaigns and community outreach grants in targeted counties. During the summer months alone, over 75 community events were held featuring WVCHIP promotion or outreach in some form throughout West Virginia in an effort to increase enrollment and awareness of the program along with a message focused on the importance of immunizations. As enrollment has increased, the partnership has evolved in working on health awareness campaigns, such as childhood obesity, immunizations, and the importance of a medical home.

Based on survey data from "Health Insurance in West Virginia", WVCHIP continues to prioritize/target outreach efforts to fifteen counties of the state with either higher numbers or percentages of uninsured children.

The faith community plays a vital role in supporting families and nurturing the development of children, by integrating faith, access to care and health of the whole person. Health ministries, parish nurse programs, congregations and other faith-based organizations are getting acitvely involved in tending directly to the health concerns of their members and the community. Faith organizations that sponsor community-based programs such as child care centers, food pantries and summer camps are becoming more attentive to the problems children face.

For this reason, WVCHIP collaborates with the faith community in an effort to educate and support families in obtaining health care coverage and promoting healthy lifestyles.

The WVCHIP has partnered with programs within OMCFH that include HealthCheck, Children's Dentistry, Birth to Three (Part C) and Right From The Start to assist in coordinating outreach efforts.

HB 4021, the Health Care Reform bill, passed the last day of the 2006 legislative session. The best part of HB 4021 is the expansion of the WVCHIP. The WVCHIP currently insures children in families with incomes below 250% percent of the FPL, which began July 1, 2008. HB 4021 increases this eligibility to 300 percent of the FPL, which has been reported to be $60,000 a year for a family of four. It is projected that 4,000 plus children will, over the next several years, enroll in CHIP as a result of this expansion. The children in families between 200 and 300 percent of the

FPL will be required to pay monthly premiums, deductibles and copayments. The expansion of CHIP is projected to increase from 94% of West Virginia children who currently have health insurance to 97%. This will nearly be universal health care coverage for children in West Virginia.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	250

Notes - 2011
Pregnant women are not covered under CHIP. All teen pregnancies are covered by Title V.

Narrative:
The percent of the FPL for Medicaid eligibility for infants up to one year of age and pregnant women is 150%. West Virginia CHIP does not provide medical coverage for pregnancy but refers all pregnant teens to the OMCFH/Title V for coverage.

Medicaid and the OMCFH share a common commitment to the goal of ensuring healthy births, reducing the incidence of low birth weight, and improving the health status of West Virginia's children. These agencies also recognize the importance of maximizing scarce fiscal resources and the benefit of collaborative efforts in the development of programs that support shared goals. West Virginia's efforts to improve the health status of pregnant women and children have been successful over time as evidenced by broadened medical coverage, streamlined medical eligibility processes, shared government funding for targeted populations, targeted outreach, risk reduction education, and development of comprehensive programs that address both medical and behavioral issues.

Early preventive prenatal care and education are recognized as the most effective and cost effective ways to improve pregnancy outcomes. West Virginia's Perinatal Program, RFTS Project, was birthed in 1989 as a partnership between OMCFH and WV Medicaid as a systematic approach to provide access to early and adequate prenatal care to low-income pregnant women and infants. Currently, RFTS provides comprehensive perinatal services to low-income women up to sixty (60) days postpartum and care coordination for Medicaid eligible infants up to one (1) year of age. Right From The Start also provides direct financial assistance for obstetrical care for West Virginia pregnant women who are uninsured or underinsured and are above income guidelines for Medicaid coverage. These pregnant women may qualify for assistance for prenatal care if they are a WV resident, have income between 150%-185% of the FPL, are a pregnant teen age 19 or under, or are a non-citizen. Under this Title V funded service, women who have no funding source for prenatal care coverage or have not yet been approved for coverage can receive assistance for payment of their first prenatal visit, ultrasound, and routine laboratory procedures if ordered on their first visit

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
The Division of Research, Evaluation and Planning within the OMCFH has received a grant from HRSA for State Systems Development Initiatives since 1996. The Research Division has used these funds to increase capacity and access data files throughout the Bureau and beyond. The OMCFH Research Division has access to both birth and death files on a regular basis from Vital Statistics, birth defects data, childhood lead screening data, Medicaid eligibility files, newborn metabolic screening from the State Laboratory, high risk and hearing screening data collected on the Birth Score card through WVU, CSHCN data, and the states's perinatal program data.

The following databases are housed in OMCFH: BTT, Breast and Cervical Cancer Screening, Family Planning, RFTS, Maternity Services, Newborn Metabolic Screening, Newborn Hearing Screening, HealthCheck, CSHCN, Oral Health, Pre-employment, Early Childhood Health, Adolescent Health Initiative, Abstinence Education, Systems Point of Entry, Birth Defects, SIDS/SUID, Childhood Lead Poisoning Prevention, PRAMS, WISEWOMAN, Kids First, and HAPI.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2011

Narrative:
The 2009 Youth Risk Behavior Survey (YRBS) was completed by 1,670 students in public high schools in West Virginia during the spring of 2009. The results are representative of all students in grades 9-12.

The weighted demographic characteristics of the sample are as follows:
Males 51.2% Females 48.8%
9th grade 28.6% 10th grade 25.0% 11th grade 23.4% 12th grade 22.8%
White 93.3%
African American 5.0%
Hispanic/Latino 0.8%
All other races 0.4%
Multiple races 0.5%

Students completed a self-administered, anonymous, questionnaire. Survey procedures were designed to protect the privacy of students by allowing for anonymous and voluntary participation. Local parental permission procedures were followed before survey administration. The YRBS is one component of the Youth Risk Behavior Surveillance System developed by the Centers for Disease Control and Prevention in collaboration with representatives from state and local departments of education and health, other federal agencies, and national education and health organizations. The Youth Risk Behavior Surveillance System was designed to focus the nation on behaviors among youth related to the leading causes of mortality and morbidity among both youth and adults and to assess how these risk behaviors change over time.

School Level - All regular public schools containing grades 9, 10, 11, or 12 were included in the sampling frame. Schools were selected systematically with probability proportional to enrollment in grades 9 through 12 using a random start. Eight schools were sampled with certainty because they had a higher proportion of minority students.

Class Level - All classes in a required subject or all classes meeting during a particular period of the day, depending on the school, were included in the sampling frame. Systematic equal probability sampling with a random start was used to select classes from each school that participated in the survey.

Percentage of students who smoked cigarettes on one or more of the past 30 days = 21.8% overall; 21.2% for males and 14.8% for females; 16.4% of ninth graders; 19.9% of tenth graders; 24.2% of eleventh graders; and 27.9% of twelfth graders.

Percentage of students who used chewing tobacco, snuff, or dip on one or more of the past 30 days = 14.4% overall; 24.2% for males; 4.1% for females; 14.4% for ninth graders; 11.6% for tenth graders; 17.2% for eleventh graders; and 15.3% for twelfth graders.

Percentage of students who ever smoked cigarettes daily, at least one cigarette every day for 30 days = 17.7% overall; 16.3% for males; 19.2% for females; 13.6% for ninth graders; 15.1% for tenth graders; 21.6% for eleventh graders; and 21.4% for twelfth graders.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Office of Maternal, Child and Family Health, Bureau for Public Health, Department of Health and Human Resources, is the "single state agency" for maternal and child health in West Virginia. The OMCFH plans, promotes and coordinates a statewide system of comprehensive health services for women, infants, children, adolescents, and families of children who have special health care needs. The Office is known for longstanding community partnerships between the public and private sector which has ultimately resulted in improved health status and access for maternal and child health populations.

The Office of Maternal, Child and Family Health, since the 1980's, has contracted for the provision of direct health care. These contractual relationships include private sector physicians, university-medical school partners, hospitals, community health centers, and local health departments. All services are formally contracted with established performance standards portrayed in the written provider-OMCFH agreements. All enrolled Medicaid providers can perform EPSDT screening services. EPSDT providers may be either individual or groups of physicians, nurse practitioners, or a facility such as a Primary Care Center or Outpatient Clinic that hires appropriate, qualified medical staff to perform EPSDT screening services. Midlevel practitioners who meet Medicaid requirements may be EPSDT providers. The HealthCheck Program focuses on equipping Medicaid providers with the necessary tools and knowledge to carry out EPSDT screening services. The exception to this format is CSHCN, which was, until the late 1980's, administered by the former Human Services arm of the now Department of Health and Human Resources organization. This unit has maintained its direct service responsibility because of the scarcity of pediatric and pediatric sub-specialty providers in certain geographical areas of the state. The Program receives referrals from multiple sources. However, as the state has developed and improved population-based surveillance systems, more and more youngsters have been referred. It is also important to note that the state's universal risk scoring of infants, called Birth Score, was modified several years ago to assure the identification of infants with or at risk of developmental delay. These children are referred to the OMCFH administered Birth to Three Program/Part C/IDEA. In addition, OMCFH administers EPSDT, again with direct care through community provider partnerships, but we do have access to information on each child, enabling us to identify youngsters with chronic or disabling conditions for referral to CSHCN. The primary care physicians are encouraged to refer children to CSHCN, and are routinely visited by Pediatric field staff employed by EPSDT, who serve as technical resources to the medical community. The OMCFH, in collaboration with multiple agencies, family groups, and individuals, has determined several needs across the service system. The needs, as identified, have been linked to Healthy People 2010 Objectives when possible and are listed by targeted populations; i.e., perinatal, children, adolescents, and children with special health care needs as discussed in the needs assessment summary section.

Families of children with special health care needs require the same sorts of support as do families with children who do not have special needs; that is to say, they require basic health care, education, recreation, socialization, transportation, and other systems to support them in their roles as family members and to help them raise children to be healthy, responsible, competent adults. All families need these systems to be available, accessible, and responsive to their needs.

As a result of multiple surveys and public forums, several overall system needs became apparent. Within the Direct Health and Enabling Services category, West Virginia is severely lacking in respite services. Respite services are almost non-existent, even for high need, targeted population groups like Medley class members who were previously institutional residents. In addition, all focus groups reflected the importance of self-determination needs in the state. The State OMCFH received multiple documentation that reinforces this priority need.

Within the Population-based Services category, surveys and public forums, the Medley class survey and the Developmental Disabilities Council survey, show that oral health services are cited as the greatest need among adults with disabilities. There is no oral health care financing for adults in that Title XIX does not offer coverage and the previously referenced Pre-employment Project, administered by OMCFH is limited to adult TANF populations returning to the work force. Also, even when children have health care financed (Medicaid), there is poor utilization of oral health services. With a budgeted amount around $40,000 annually, the Program is able to place 100-125 eligible persons for dentures. Unfortunately, the eligible individuals approved for the Donated Dental Project have far outgrown the budgeted amount. The Oral Health Program recently created a new waiting list of clients starting with applications approved in January 2008 to the present. There are over 300 persons throughout the state on the waiting list presently and we have not been taking applications since January 2010. With such limited funding and such great need, the Donated Dental Project will never be able to even come close to clearing out the waiting list and becoming current in placements (at least placement after approval, if at all possible, ideally within a six month time period). Finally, survey results confirm that vocational transition services are in need of renewed support in West Virginia. Approximately 1/3 of survey responders indicated the need for children to receive transition or vocational planning.

Causes of infant death, low birthweight and maternal smoking must be continued to be addressed. Within the infrastructure building category, recruitment and retention of qualified medical and other service delivery personnel in WV must receive priority attention in the future. Moreover, insurance systems within the state infrastructure require modification to better accommodate children and families in WV. Recognition of CSHCN services to include reimbursement for non-traditional services such as intervention by licensed developmental specialists and other professionals must become a priority.

B. State Priorities

Each current state performance measure was selected because of the health status of the respective population and based on information derived from the Needs Assessment completed in 2005. The new state performance measures are once again based upon the Needs Assessment and have changed only marginaly from the 2005 measures.

Although West Virginia has financial woes and many health care issues such as smoking among pregnant women, infants born prematurely, infants born with low birth weight, obesity and asthma, the WV OMCFH has woven together a patchwork of funding streams to create a system of care for women, infants, and children, including adolescents and those with special health care needs. The WV OMCFH has developed strong partnerships across the state with the medical community, private sector, as well as community health centers and local health departments, all in an effort to assure access. Medicaid has purchased services for their beneficiaries at the request of Title V but they, too, are facing financial woes.

It is clear that we cannot support all current programs and services at the existing level. In response to budget shortfalls, the WV OMCFH has advocated for the purchase of those services most critical to the health of maternal and child populations--family planning, prenatal care, support of EPSDT, population based surveillance programs, CSHCN services, etc. Another strategy that the WV OMCFH has undertaken is reduction of cost wherever possible. The Family Planning Program formulary has been changed to accomodate the purchase of generic treatment medications and contraceptives. These pharmaceuticals are purchased en mass and stored at a government operated warehouse that is supported by multiple programs, including West Virginia Healthy Start/HAPI. West Virginia is also efficient with resources, often administering programs and services that are used by multiple payor sources such as Title XIX and XXI. To assure that federal resources are maximized, all uninsured children and pregnant women seeking services must apply for Title XIX. If the patient is ineligible for the Title XXI or Title XIX, Title V resources may be used to pay for their care.

The West Virginia five year needs assessment is a work in progress throughout the year, every year. In order to ensure that adequate health care is available we must continually ask our customers if their needs are being met and use data to support outcomes. With limited resources, it is essential to target areas that will have the greatest impact in improving overall health outcomes.

Through the participation of our medical advisory boards, population targeted focus groups, workgroups and other agencies who conducted surveys of shared constituencies throughout the State and use of qualitative and quantitative data, the following priorities were established for the MCH population as follows:

A. Pregnant women, women of childbearing age, mothers and infants
1. Decrease smoking among pregnant women
2. Reduce the incidence of prematurity and low birth weight
3. Reduce the infant mortality rate, focusing efforts on black infants and Sudden Unexplained causes

B. Children and Adolescents
1. Assure that children and adolescents access preventive dental services
2. Reduce smoking among adolescents
3. Reduce obesity among the state's population
4. Decrease the incidence of fatal accidents caused by drinking and driving
5. Increase the percentage of adolescents who wear seat belts
6. Reduce accidental deaths among youth 24 years of age or younger

C. Children with Special Health Care Needs
1. Maintain and/or increase the number of specialty providers in health shortage areas
2. Increase respite options for caregivers of children with special needs

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	18	25	27	26	43
Denominator	18	25	27	26	43
Data Source				Newborn Metabolic Screening	Newborn Metabolic Screening
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

The West Virginia Newborn Screening Program, housed within the Office of Maternal, Child, and Family Health within the Bureau for Public Health, has partnered with the State Laboratory and expanded newborn screening to include twenty-nine disorders which adheres to national standards recommended by the United States Department of Health and Human Services Secretary's Advisory Committee on Heritable Disorders and Genetic Diseases. The full panel of screens was implemented in February, 2009.

Newborn Metabolic Screening is a critical public health function by which all newborns are screened shortly after birth for selected disorders with potentially adverse consequences that can be identified and treated before the illness becomes apparent. For many years, even before mandatory legislation, the Office of Laboratory Services (OLS) worked in tandem with the OMCFH to develop capacity to expand the newborn screening panel. Prior to 2005, WV screened for only five disorders, while in 2007 had the ability to screen for ten disorders and in February, 2009 began screening for all 29 nationally recommended disorders. It is the partnership between the Office of Laboratory Services and the Office of Maternal, Child and Family that has allowed this expansion to occur while also being able to provide follow-up and genetic services to all infants that are born within WV borders. The WV Newborn Screening Program boasts coordination of services between birthing facilities, insurance companies, West Virginia University who provides genetic and cystic fibrosis expertise, as well as, with the endocrine, metabolic/genetic and hematology specialists across the state.

In 2009, 98.9% of infants born in the state of WV received newborn screening. In conjunction with the Office of Laboratory Services, the Newborn Metabolic Screening Program ensures that infants are screened for inborn errors of metabolism before hospital discharge. All abnormal test results are followed by Office of Maternal, Child and Family Health staff and confirmed abnormalities receive case management, with assistance from the Genetics Program at West Virginia University. The Office of Maternal, Child and Family Health provides, free of charge, regardless of family income, formula for those with confirmed PKU. The OMCFH, using Title V dollars, in the past reimbursed the State Lab for all newborn screening specimens. With the passage of the Newborn Screening Rules during the 2008 Legislative session, the Bureau for Public Health is now able to bill the hospitals for every infant who receives a screen. The cost of the newborn screening system is included in this charge.

The Genetics Program at West Virginia University provides genetic clinics at 6 strategic locations throughout the state, offering diagnosis, treatment and counseling and was historically funded using Title V dollars. The Genetics Program costs, associated with newborn screening are now included in system charges, since they provide medical support for primary practitioners serving affected newborns.

Staff routinely visit birthing hospitals as a means of identifying and resolving any problems or concerns. Linkage of data from the State Laboratory and the Program create a more efficient process.

Educational information on the expanded panel of disorders has been developed for use by physicians and families. The Newborn Screening Program website is continually updated to include progress on expansion efforts and information on disorders as well as establishing links to supportive information.

Expanding newborn screening incrementally has afforded OMCFH the opportunity to build State

laboratory capacity as well as to begin billing hospitals to recoup system costs between expansion phases.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All abnormal test results are followed by OMCFH case management.		X		
2. The Pediatric Genetics Program at WVU provides six subspecialty clinics throughout the State of West Virginia.				X
3. An active advisory committee assists with policy and program development.				X
4. The NBS Project staff work collaboratively with the State Lab to ensure screening before hospital discharge.				X
5. Formula for PKU patients is provided free of charge, regardless of income, by OMCFH.		X		
6. Linkage of data between OMCFH and the State Lab creates efficiency.				X
7. Formal relationships have been developed with Schools of Medicine to assure availability of medical experts.				X
8. WV currently screens for 29 disorders (includes hearing).			X	
9. The Bureau for Public Health generates revenue by billing the birthing hospital for each live birth for newborn screening.				X
10.				

b. Current Activities

It is the goal of the OMCFH Newborn Metabolic Screening Program to screen every newborn in WV for disorders to ensure diagnosis and treatment before the consequences of the disease become apparent ensuring the greatest opportunity to live a normal, productive life. Long-term benefits include a better quality of life for the child and his/her family and considerable cost savings for the insuring payers and the taxpayers of the State of West Virginia.

The OMCFH Newborn Metabolic Screening Program staff and the infant's physician are immediately notified by the State Laboratory of all abnormal screening results. In turn, the OMCFH staff discusses with the infant's parents/legal guardian and the primary care physician the need for a repeat screening or a confirmatory test. The OMCFH staff tracks each newborn with an abnormal test result to be certain that the newborn receives prompt and appropriate care. Since initial screening tests give only preliminary information, more precise testing must follow. Thus, an abnormal screening result indicates that further testing is necessary to confirm or eliminate the diagnosis suggested by the screened disorder. Infants with an abnormal screening result are also referred to an endocrinologist, a hematologist, a pediatric pulmonologist and/or to the state's only pediatric geneticist. All referred newborns undergo confirmatory testing and receive treatment if indicated. Newborn screening tests are only performed by the State Laboratory.

c. Plan for the Coming Year

The Office of Maternal, Child and Family Health will maintain its relationships with the State Laboratory, the Newborn Metabolic Advisory, WVU Genetics Program, birthing facilities, Medicaid, insurance companies and the March of Dimes. WVU Genetics, with the Newborn Metabolic Program financial support, is seeking additional nutritional counselors, clerical staff and

an additional geneticist to work with the State's only geneticist, Dr. Hummel, because of the expanded panel. The follow-up component of the Newborn Metabolic Screening Program is housed within OMCFH and an additional follow-up nurse was hired and is currently in training.

Processes were developed and will be refined as necessary to purchase supplements needed for those infants diagnosed with a disorder. Partnership with WIC will continue to enable the infant to receive nutritional products that he/she may be eligible for beyond that provided for by the OMCFH.

Information on the more recently added newborn disorders is being developed to be given to physicians. A new brochure for families was developed and is being distributed to the hospitals and OB/Gyns to be given to expectant and/or new parents.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**21299**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	21209	99.6	9	2	2	100.0
Congenital Hypothyroidism (Classical)	21209	99.6	426	15	15	100.0
Galactosemia (Classical)	21209	99.6	66	8	8	100.0
Sickle Cell Disease	21209	99.6	116	1	1	100.0
Biotinidase Deficiency	21209	99.6	70	7	7	100.0
Cystic Fibrosis	21209	99.6	134	8	8	100.0
Homocystinuria	19454	91.3	1	0	0	
Maple Syrup Urine Disease	19454	91.3	20	0	0	
beta-ketothiolase deficiency	19454	91.3	5	0	0	
Tyrosinemia Type I	19454	91.3	21	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	19454	91.3	0	0	0	
Argininosuccinic	19454	91.3	0	0	0	

Acidemia						
Citrullinemia	19454	91.3	1	0	0	
Isovaleric Acidemia	19454	91.3	2	0	0	
Propionic Acidemia	19454	91.3	10	0	0	
Carnitine Uptake Defect	19454	91.3	6	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	19454	91.3	2	0	0	
Multiple Carboxylase Deficiency	19454	91.3	0	0	0	
Trifunctional Protein Deficiency	19454	91.3	0	0	0	
Glutaric Acidemia Type I	19454	91.3	2	1	1	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	19454	91.3	117	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	19454	91.3	3	1	1	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	19454	91.3	3	0	0	
3-Hydroxy 3-Methyl Glutaric Aciduria	19454	91.3	2	0	0	
Methylmalonic Acidemia (Mutase Deficiency)	19454	91.3	0	0	0	
S-Beta Thalassemia	21209	99.6	0	0	0	
Mitochondrial Acetoacetyl- CoA thiolase deficiency (3-ketothiolase)	19454	91.3	5	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	60	65	56.1	65	60
Annual Indicator	56.1	56.1	56.1	56.2	56.2
Numerator		39000	39060	39100	39100
Denominator		69567	69567	69567	69567
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60	60	60	60	60

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Parents or legal guardians are involved in the Client/Family Assessment process and the development of the Client/Family Care Plan. A multi-disciplinary team approach is used to provide care-planning and care-coordination to CSHCN and Birth to Three Part C/IDEA participants. The multi-disciplinary team includes the child/parent, physicians, nurses, social workers, therapists, school systems, vendors and community services supports who are providing care for the child. Team members, led by the CSHCN nurse and/or social worker, collaborate with the family in developing an appropriate, comprehensive care plan for the child.

Birth to Three, Part C/IDEA for infants and toddlers with developmental disabilities, assures that families have a choice of credentialed practitioners to provide services agreed upon during the Individual Family Service Plan (IFSP) development. Families also have access to other families who have similiar experiences and can provide support and resource information. These parent to parent resources are available statewide with a parent coordinator assigned a specific geographic region of the state. Eight parent to parent coordinators are paid by BTT. In addition, families are seated on the Interagency Coordinating Council/ICC alongside other stakeholders. The ICC is charged with providing advice and guidance to the state Part C system administered by MCFH.

Care plans for children under 18 participating in CSHCN are developed along with their parents to assure medical, social and appropriate developmental issues are accommodated. The CSHCN Program, using Title V funds, continues to support the Parent Network, administered in partnership with the Center for Excellence in Disabilities (UAP) at WVU, with staff strategicaly

located throughout the state. These Parent Network Specialists assist families with making informed choices about healthcare to promote treatment options, community resources, and conduct outreach activities to families, healthcare professionals and other appropriate groups.

During CY 2009, 357 new Client/Family Care Plans were completed and 2,451 were updated. The initial and updated Care Plans were done to assure a continuum of comprehensive medical care and includes transition to adult care when appropriate. Plans are updated when change in treatment or medical care is recommended by the parent or other member of the team, or an additional client/family need is identified. The client/family then reviews and signs the care plan with each update and is provided with a copy for their file. Transition services also involve parents, education specialists and other interested parties. Transition screening tools for middle adolescents and young adults were completed by the client/family and used by the care coordinator in providing resources and transition services; 1,072 transition services were provided to youth, ages 14 to 21 years of age.

In response to the CSHCN Family Survey completed in 2006, greater emphasis was placed on the comprehensive approach to the entire family and their medical and social service needs. Educating families as to what care coordination is and how they can benefit from those services continued to be a priority in 2009. Informational material, including pamphlets and posters, were developed and distributed informing families and the public about the components of care coordination and how to access services from the CSHCN Program.

In 2009 the CSHCN provided employee in-service training to staff and supervisors of the DHHR by participating in regional meetings. Emphasis was placed on care coordination and the collaboration with local health care facilities to provide nursing and social services in community clinic settings.

To support the CSHCN staff in their commitment to provide care coordination to the families they serve, a statewide staff conference was held in September 2009. Topics included an overview of the program/services offered through the Division of Rehabilitation Services, Foster Care Program, WIC, Emergency Medical Services for Children and Children with Disabilities Community Services. Presentations on childhood obesity, genetics, motivational interviewing and patient education were included.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaboration with Marshall University in Parent Partners in Education (PPIE) funding results in parent advocates placed in Cabell-Huntington Hospital PICU and Pediatric Clinic.		X		
2. Parent/Professional Collaboration Conference sponsored by OMCFH and Marshall University Pediatrics.		X		
3. Survey of parents to determine priority topics of interests/concerns conducted by Center for Excellence in Disabilities through contract with OMCFH.		X		
4. Parents participate as part of the care coordination team for development of individual care plans in Part C and CSHCN Programs.		X		
5. Copies of Care Plans and updates are given to the child's parent.				X
6. Care Notebook and Resource Manual were revised with the assistance of the PNS and families and distributed to families and applicants.		X		
7. On-going training of BTT practitioners beyond their		X		

professional licensure is required.				
8. Paid Parent Coordinators, one in each of the 8 Birth to Three Regions are available to families, and 5 Parent Network Specialists.				X
9. All BTT participants self select practitioner offering services.		X		
10.				

b. Current Activities

Partnering with parents in decision making at all levels of CSHCN is demonstrated through the participation of Parent Network Specialists (PNS) and parent participion in designing care plans for their children and participation in Program changes. The PNS system is administered by the Center for Excellence in Disabilities (CED), to ensure impartiality. PNS, in cooperation with the CSHCN Program, continued the process of updating the Care Notebooks including the resource contact section to assure clients/families receive current and accurate information to assist them in finding needed resources.

The CSC unit continues to develop and update a resource library accessible to all staff members. Included are numerous topics addressing the medical, social and educational services available to families throughout the state. The library also serves as an educational information site for enhanced skill-building.

During FY 2008, patient/family assessments and care plans were completed or updated for all program-enrolled children through home visits, clinic visits and/or other face-to-face contacts. Priority is given to newly enrolled children and to children requiring transition services; pre- and post-surgical care; private duty and intermittent skilled nursing; nutritional assessment; child protective services; technology dependent; and those requested by physicians, clinics, or other agencies. Continued emphasis is placed on care coordination services.

c. Plan for the Coming Year

The possibility of CSHCN nurses and social workers providing care coordination services in offices of primary care physicians will be explored. The process will include the development of informational material to explain and promote the advantages to the children, families and physicians of providing these services in the medical home. The CSHCN Program will continue to provide services to all children with special health care needs in West Virginia by expanding the role of the care coordinators in community based clinics when possible.

The Health Resources and Services Administration (HRSA), Maternal Child Health Bureau (MCHB) recently announced the awards of Family-to-Family Health Information Center (F2F HIC) grants to ten new organizations. WV was one of the ten states. As of June 1, 2009, F2F HICs were operational in every state and the District of Columbia. F2F HICs assist families of children and youth with special health care needs/disabilities (CYSHCN) with support, information, resources, and training. Family Voices, Inc., as the National Center for Family/Professional Partnerships (NCFPP), provides technical assistance to support these activities. MCHB recently awarded a new 4-year cooperative agreement to Family Voices to continue to provide technical assistance to the F2F HICs throughout the country.

As the WV CSHCN Program launched phase one of the comprehensive program redesign, focus was attributed to the first component of cultural competence, awareness of one's own cultural worldview. Through two interactive activities, CSHCN staff and PNSs identified aspects of themselves as individuals as well as aspects of the program which are a strength in supporting a culturally competent system of care, strategies that could strengthen cultural competence, and the next steps for action. To address cultural competency during Phase 1 of program redesign, staff identified strategies of: 1) translating literature, letters and materials to Spanish for public awareness and service delivery to pockets of this ethnic group throughout WV; 2) training on the topic of "The Culture of Poverty" is desired prior to implementing home visits for assessment and

care planning; and 3) revision of form letters, care notebooks, etc to ensure a reading level no higher than 4th grade as recommended by National Initiative for Children's Healthcare Quality Jumpstart Improvement Program of WV.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	60	60	60	58	58
Annual Indicator	56.9	50.5	50.5	51.0	51.0
Numerator		35100	35100	35500	35500
Denominator		69567	69567	69567	69567
Data Source				CSHCN 2005-2006	CSHCN 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55	55	55	60	60

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
Information about a child's primary care provider is collected by the Systems Point of Entry Unit (SPE) during initial intake, and by CSHCN Program staff each time a child presents for service. During CY 2008, 1,551 children who received CSHCN Program services had an identified medical home. This represents 90% of children enrolled and in pending status with the CSHCN Program. SPE service coordinators link children without an identified medical home to the state's expansive network of community health centers and to primary practice clinicians for medical care. All children receiving benefits through the WV Medicaid Program, including those participating in the CSHCN Program, are assigned a primary care physician. Children diagnosed with mental health needs; ie socially emotionally disturbed (SED), etc. are managed by the Bureau for Behavioral Health and Health Facilities within DHHR.

Following the Public Employees' Insurance Agency's lead, WVCHIP adopted a voluntary medical home program for its members on March 1, 2007. Under this program, members agree to utilize one physician for all their primary care needs selected from a directory of qualified physicians specializing mostly in pediatric or family medicine. In exchange, co-payments for all visits to a

member's designated medical home are waived. Providers receive full payment for services from WVCHIP. No formal referral process to specialists or other care outside the medical home is required by providers.

Copies of medical records, depicting care provided by CSHCN, are sent to the participating child's primary care provider to assure coordination of care. Progress reports related to Part C/Birth to Three are also shared with the child's medical home with parental consent.

Marshall University has a medical program focusing on the needs of children who are homeless. The program provides care coordination for children staying at the Huntington City Mission and its Project Hope transitional living apartments. The effort is funded by a 5 year, $250,000 Healthy Tomorrows Partnership for Children Program grant from the American Academy of Pediatrics in cooperation with HRSA, Bureau for Maternal and Child Health. Marshall's program is the first in the state to be awarded one of these grants. The goal of the project is to provide a medical home for this unique group of children with special health care needs. The coordination of services to these families will improve children's health by decreasing hospitalizations, emergency room visits and school absences. In addition to meeting children's acute care needs, the program hopes that early identification and treatment of developmental or school problems will enable these children to become healthy, productive West Virginians. In FY 2010, OMCFH augmented the Marshall University grant by contributing $36,000.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 95% of WV children have insurance coverage		X		
2. State CSHCN Program provides extensive care coordination		X		
3. Medicaid, CHIP, PEIA and commercial carriers are requiring use of a medical home				X
4. The U.S. Scorecard ranked WV number 8 for percent of children who have a medical home			X	
5. The U.S. Scorecard ranked WV number 1 for percent of children whose personal doctor or nurse follows up after receipt of specialty care services				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Efforts are made to coordinate the CSHCN Program specialty care provided within the child's medical home and to keep the primary care physician informed of treatment plans. Care coverage is provided throughout the state in either a specialty care physician's office or at a CSHCN clinic site closest to a child's home. The child and the principal care-givers are informed of treatment options and are involved in development of the client/family care plan for the child. Care is continued until the child's 21st birthday with transition services available to prepare for independence.

In 2009, OMCFH saw a need for care coordination and medical records tracking for children in the Foster Care System. As a result of identifying this need, OMCFH offered a proposal to the Bureau for Children and Families to provide health care coordination for children placed in the Foster Care System in West Virginia. The project is coordinated by the Division of Infant, Child and Adolescent Health within OMCFH, which includes HealthCheck, Systems Point of Entry and the CSHCN Program. Ultimately, this process will provide a framework for the child's health care

and development tracking using comprehensive medical care coordination. Foster care families will be educated on the child's diagnosis and current treatment and follow-up will accompany the child regardless of placement status. Work on implementation of this program will continue through 2010.

c. Plan for the Coming Year

CSHCN will continue to work with the WV Medicaid Managed Care, and other insurers to assure the needs of children with special health care needs are addressed. The planned expansion of WV Medicaid Managed Care through contracted health maintenance organizations, will have a continuing impact on the provision of care for children with special health care needs. The Medicaid Program plans that all Medicaid beneficiaries will be covered by a health maintenance organization within the year. About 55,000 people who receive SSI will start receiving Medicaid benefits through managed care. Under the state's current fee-for-service model, a person can visit any provider who accepts Medicaid. In managed-care plans, people must visit doctors, dentists and other health providers who have signed up with a managed-care company's network. This may present a challenge for children with special health care needs.

CSHCN will continue to work with the WV Chapter of the American Academy of Pediatrics to encourage the medical community to refer children with chronic, debilitating conditions to the CSHCN Program.

CSHCN will continue to collaborate with another office within the Bureau for Public Health, Office of Nutrition Services' Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to assure children who are age eligible to receive WIC services are identified.

The WV Medicaid Program does not provide coverage of nutritional or feeding supplements taken by mouth. Young adults receiving such supplements, paid for by Title V, lose of the funding for these medically necessary prescribed supplements when the young adult transitions from CSHCN at age 21 years, which often creates a hardship. The WVU Center for Excellence in Disabilities' (WVUCED) nutritionist continues to work on the issue of formula needs, and OMCFH supports this effort using Title V funds.

The CSHCN will continue to expand care coordination services to a larger population of children with special health care needs in the state including those who are not enrolled in CSHCN. The CSHCN staff will continue to provide care coordination services in the Genetic clinics that are held in 6 cities across the state. Each of these clinics is held at least 6 times per year, and some of them are held 18 times per year. The care coordination service provided by CSHCN social workers who assist children and families with resource and referral information. This type of services will be offered in additional settings as the need arises.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	65	65	65	65	65
Annual Indicator	59.8	59.8	64.2	64.6	64.6
Numerator		41570	44650	44950	44950
Denominator		69567	69567	69567	69567
Data Source				CSHCN Survey	CSHCN Survey

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	65

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
The Systems Point of Entry (SPE) Project, housed within OMCFH, is a telephone hot-line and referral service that identifies families that do not have Medicaid, CHIP or private insurance coverage at the time an application to participate in the CSHCN Program is made. Families without resources to pay for medical services must apply for Title XIX and Title XXI, and must be denied by these sources, prior to Title V payment initiation.

During CY 2009, 98% of children participating in CSHCN were Medicaid beneficiaries. To assure that families have the best available coverage for their child's medical care, the CSHCN Program required all applicants to first apply for Medicaid and WVCHIP at their local Department of Health and Human Resources (DHHR) Office. Verification of their application is done through receipt of a written notice given to the family and/or by accessing RAPIDS, the Medicaid eligibility data system. Information submitted to the DHHR office during this process is also used as the determinant of a child's financial eligibility for the CSHCN Program.

In 2009, $300,000 was donated by Mountain State Blue Cross/Blue Shield to purchase hearing aid services and supplies for children ages 3,4,5,or 6 years who lack insurance coverage for this benefit. This Project, administered by the Office of Maternal, Child and Family Health, Department of Health and Human Resources, is part of Governor Manchin's Kids First Initiative: Healthy and Ready to Learn.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 95% of WV children have insurance coverage (Medicaid, CHIP, Private carrier)		X		
2. CSHCN requires Medicaid and CHIP applications, to ensure Title V resources are last resort				X
3. Coordination between CSHCN and Social Security Administration facilitates access to SSI		X		

4. CHIP expanded eligibility to 240% FPL with plans for expansion to 300% FPL in yearly 20% increments				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
WV CHIP, CSHCN, Birth to Three, and Right From The Start Programs continue efforts to involve the faith based community in identification and outreach to uninsured and underinsured children.

Program Specialists within the EPSDT Program, continue to assure the availability of CHIP applications at all community health centers, physician offices, and local health departments, etc. This availability is monitored by the Quality Assurance Unit in OMCFH.

Patients receiving medical treatment and/or care coordination through the CSHCN Program have their health care financed by Medicaid, CHIP, private insurance or Title V funds. Families with income of 200% of the Federal Poverty Level or below may be eligible for Title V sponsored services if they have an eligible/covered diagnosis. The Program does not have sufficient resources to act as an insurer for every chronic debilitating condition. For example, Title V does not provide payment for treatment of asthma or diabetes. Continued financial eligibility is determined on a yearly basis using a computer generated letter asking families to reapply for Medicaid and CHIP to assure Title V funds are used as payor of last resort. The care coordinator reviews financial information as well as determines continued medical eligibility.

c. Plan for the Coming Year
Building on outreach efforts for the past year, CSHCN will continue efforts to make potential recipients aware of services available through CSHCN. To expand CSHCN outreach efforts, the DHHR Division of Management Information Systems will identify approved or denied Medicaid beneficiary children (age 0-20) who have a disability. The system will generate a monthly report to use in CSHCN outreach efforts by the Systems Point of Entry unit. The SPE unit will mail identified families information about available CSHCN Program services and care coordination. This will augment population based surveillance efforts and children identified as a consequence of an EPSDT screen.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	75	75	75	90	90
Annual Indicator	73.1	73.1	89.7	89.9	89.9
Numerator		50850	62420	62520	62520
Denominator		69567	69567	69567	69567
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	90	90	

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
In CY 2009 an informational pamphlet was given to each family at the time of enrollment. The pamphlet provided information about the CSHCN Program, eligibility criteria for continued service, services offered including aspects of care coordination and a listing of the patient/family rights and responsibilities.

The CSHCN Program worked diligently to expand care coordination services to a larger population of children with special health care needs, including those who are not enrolled in the CSHCN Program. One of the major accomplishments in 2009 was a collaborative effort between the CSHCN and the WVU School of Medicine/Physician's Office Center. The Physician's Office Center (POC) began managing several specialty care clinics that were previously managed by the CSHCN. In assuming management of the clinics, the POC can schedule clients who are not enrolled in the CSHCN, but are in need of care coordination services. The CSHCN provides a nurse and social worker to offer care coordination services in each of these clinics, providing services to a broader population of children with special health care needs. Similar efforts are underway with Marshall University/Joan C. Edwards School of Medicine. The CSHCN Program also worked in collaboration with Charleston Area Medical Center (CAMC) - Women & Children's Hospital to see patients diagnosed with cystic fibrosis in their clinic setting. Medical management and genetic counseling was provided by CAMC while the CSHCN Program supplied the nursing and social service components including care coordination.

WV BTT received from the U.S. Department of Education the highest ranking possible for it's administration of Part C which includes evaluation of timely service delivery, parent knowledge of rights and responsibilities, parent satisfaction and measured child performance milestones. A 2007 Family-Centered Services Satisfaction Survey is included as an attachment.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Parents participate in policy and procedures development for WV Birth to Three, Hearing Screening and CSHCN.		X		
2. Collaboration with WV Medicaid to optimize resources and plan efficient use of funds.				X

3. CSHCN collaborates with other OMCFH programs to coordinate needed services efficiently.				X
4. CSHCN Medical Director participates on Medicaid policy committee sharing input from families.				X
5. CSHCN Program Advisory includes medical providers, service providers, and parents.		X		
6. Survey of BTT parents reflect satisfaction and child performance improvement.				X
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN quality assurance component was strengthened by continuation of an internal process designed to monitor staff documentation in enrolled patient records. Each month the CSHCN Director of Nursing and the Director of Social Services review a portion of each of their assigned staff's work using an Internal Chart Review form, which identifies important elements in care management and case recording. This process identifies areas that need improvement and serves as a basis to identify staff training needs and evaluation. The system serves to augment the periodic clinic/field office site visits completed by the CSHCN Director of Nursing and the Director of Social Services. An electronic data system was developed by OMCFH's Division of Research, Evaluation and Planning for recording and tracking of completed reviews. This allowed the CSHCN nurses and social workers to track response times from the time of inquiry, to the time of authorization and then to the delivery of patient equipment or services.

c. Plan for the Coming Year

The CSHCN Program differentiates itself from other programs/payers by continuing to emphasize the importance of care coordination services. Nurses and social workers are trained to view the family as a whole and assess their needs, both medical and social, and link them with available resources and community services.

The Parent Network Specialists (PNS) will continue to provide resource information, support families in dealing with educational issues, and plan regional workshops to include information on transition services. The PNS will continue to develop parent support groups in their assigned areas.

The ability to serve more children with special health care needs continued with the collaboration between the CSHCN Program and the Physician's Office Center, West Virginia University (WVU) School of Medicine in Morgantown. The CSHCN Program provides the nursing and social service components, while the medical management of the clinic patients has been turned over to our partners at WVU. Exploring this type of collaborative effort with other medical providers and facilities will continue in 2010.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	6	6	6	41.3	42

Annual Indicator	5.8	41.3	41.3	41.4	41.4
Numerator		28700	28700	28800	28800
Denominator		69567	69567	69567	69567
Data Source				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	43	43	43	43	43

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
A goal of the CSHCN nurse and social worker is to link youth and their families to community, medical and educational resources to assist in preparations for independent living as adults. One way to obtain this goal is in partnership with the West Virginia Division of Rehabilitation Services (WVDRS). During the CSHCN All-Staff Conference, a representative from the WVDRS provided a presentation about the changes in WVDRS, highlighting an increase in funding available for client services. In CY 2009, 267 referrals were made to the DRS by the CSHCN Program.

The CSHCN program administrators also sought training for nurses and social workers in the area of guardianship, conservatorship, wills and financial planning. This has been an important benefit to families and clients.

The CSHCN nurses and social workers also assist clients and families with the transition process using the Transition Screening Tools which are completed and updated with adolescents ages 14, 16, and 17. Young adults ages 18 and 20 also prepare to age out of the Program by completing a Transition Screening Tool with the CSHCN nurse or social worker. In CY 2009, 413 Transition Screening Tools were completed.

In CY 2010, the CSHCN Program, in collaboration with Marshall University Pediatrics, will begin providing care coordination services in a monthly transition clinic which will be held in a pediatrician's office and will serve young adults with chronic medical conditions.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. CSHCN offers transition services to all Program participants beginning at age 14.		X		
2. WVU Center for Excellence in Disabilities has a transition advisory.		X		
3. Marshall University School of Medicine is collaborating with Title V on transition programming.		X		
4. Participants are encouraged to access VR counseling in schools.		X		
5. WV established required certification for interpreters.				X
6. Division of Rehabilitation Services has Cooperative agreements with all 55 county school systems.				X
7. Throughout WV, 63 rehabilitation counselors are assigned to work with public and private schools.		X		
8. Rehab counselors assisted 876 students with disabilities in developing individualized plans for employment.		X		
9. Fifty-two percent of the case closures with rehabilitation services were employed.		X		
10.				

b. Current Activities

The CSHCN electronic data system produces reports identifying adolescents 14 through 21 years of age as a tracking system for social workers and nurses. These reports are produced on a monthly basis and used by CSHCN staff when determining need for frequency of contact with clients in providing transition services.

School transition is an area where progress is actively occurring including: statewide and district level workshops and forums; transition targeted teleconferencing; transition assessment resource development; focus on improving achievement; attention to differences in graduation and dropout rates for students with disabilities and all students; efforts to increase collaboration and coordination with WV Division of Rehabilitative Services (DRS), Office of Maternal, Child and Family Health/Children with Special Health Care Needs (OMCFH/CSHCN) and the Department of Education (DOE); development of inclusive educational models and strategies to improve access; and the opportunity to progress in the general education curriculum.

In 2009, the CSHCN Program began working with Dr. James Lewis from the Joan C. Edwards School of Medical Pediatrics in Huntington, WV, to provide the nursing and social services component in the transition clinic held in Dr. Lewis' practice. Transitions planning and care coordination was provided by the CSHCN staff to patients 14 through 20. This collaborative effort will continue in the future.

c. Plan for the Coming Year

The OMCFH has representation on the State Developmental Disabilities Council and shares data and programmatic information that can be used to pursue system change, increase service or support availability or otherwise promote positive and meaningful outcomes. Several examples include coordinated advocacy for the passage of an expanded newborn metabolic legislation, coordination with Vocational Rehabilitation on policy and practice to promote self-determination and transition planning for youth, and CSHCN Program staff participate in advocacy training and public policy.

A greater emphasis will be placed on transition services by collaboration between state and local school systems, Division of Rehabilitation, medical care providers, social service agencies and the CSHCN Program. Transition screening forms will be revised and updated to better determine the needs of the adolescent and their family.

While there are a number of services and programs that are designated to assist people with disabilities in various facets of training and employment assistance, central easy access to these services across agencies and providers is lacking. A forum where stakeholders can work together to bring about change is needed.

A team of stakeholders continues to assist with the core design of the strategic planning process. This team consists of representatives from: The Bureau for Medical Services, Goodwill Industries of KYOWVA, WV Developmental Disabilities Council, Workforce WV, People's Advocacy Information and Resource Services Center, Bluefield State College, Office of Special Education Assistance, WV Mental Health Planning Council, Job Accommodation Network, the CED and DRS. Technical assistance is provided by CESD and the program staff of CED.

Varieties of assessments across different groups continue to be completed. The voices heard within the state from a wide audience (education, business, advocates and people with disabilities and their families) provides positives, challenges and ideas for improvement.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	95	95	95	95
Annual Indicator	93.5	90.3	93.3	93.1	91.5
Numerator	58000	56000	57850	57710	56700
Denominator	62000	62000	62000	62000	62000
Data Source				2008 Immunization Data	2009 Immunization Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	96	96	96	96	96

Notes - 2009
WV Immunization Program 2009...numbers were provided for individual immunizations (DTaP-4: 85%, IPV-3: 94.5%, MMR-1: 88%, Hib-3: 94%, Hep B-3: 96%)...numbers were added together and divided by total number for overall percentage

Notes - 2008
WV Immunization Program 2008...numbers were provided for individual immunizations (DTaP-4: 86%, IPV-3: 93.8%, MMR-1: 94.2%, Hib-3: 96.1%, Hep B-3: 95.5%)...numbers were added together and divided by total number for overall percentage

Notes - 2007
WV Immunization Program 2007...numbers were provided for individual immunizations (DTaP: 86.2%, Polio: 94.5%, MMR: 95.1%, Hib: 96.1%, Hep B: 94.7%)...numbers were added together and divided by total number for overall percentage

a. Last Year's Accomplishments
The State's Division of Immunization Services is housed in the Office of Epidemiology and Prevention Services, Bureau for Public Health. This division works closely with local health departments, WIC, hospitals, the private practicing medical community, and other early childhood programs in an effort to get children fully immunized. Immunization data for 2009: 85% had been immunized for DTaP-4, 94.5% for IPV-3, 88% for MMR-1, 94% for Hib-3 and 96% for Hep B-3. The Division of Immunization Services and the statewide immunization coalition, West Virginia Immunization Network (WIN) have collaborated to implement the "Take Your Best Shot" campaign targeting adolescents for HPV, MCV, Tdap, chickenpox and Hep B vaccinations in 23 counties, up from 16 counties in 2009. The Division of Immunization Services worked with the WV Higher Education Policy Commission from 2006-2008 to develop a list of recommended immunizations for college enterers. WVCHIP materials were included in the State's Newborn Immunization Program packets to new mothers through the Right From The Start Coordinators.

The EPSDT Program has actively worked to ensure that children participating in the Program receive complete immunizations by age 2. The HealthCheck Program publicizes immunization schedules approved by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) in a HealthCheck Provider Manual that is used by approximately 1,200 HealthCheck providers. The providers immunize children in accordance with the schedule or they refer their clients for immunizations in accordance with the schedules to alternate pre-arranged referral sites in the community.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In 2009, WV was 22nd in the nation for completion of regularly scheduled immunizations on children between 24-35 months of age.		X		
2. The EPSDT/HealthCheck Program encourages providers to offer immunizations as part of health care.				X
3. The RFTS Project collects data on whether or not infant participants (who are up to 12 months) are up to date on immunizations.				X
4. All women giving birth in WV receive an information packet including an immunization schedule before leaving the birthing facility.		X		
5. WV does not allow non-medical exemptions for immunizations.				X
6. Partnered with West Virginia’s Immunization Network (WIN) to promote adolescent immunizations.		X		
7. Need for imunizations is promoted by RFTS, WIC and other public health programs.		X		
8.				
9.				
10.				

b. Current Activities
All women giving birth in WV receive an information packet including an immunization schedule before leaving the birthing facility. WV does not allow non-medical exemptions for immunizations.

In 2009, WV was 22nd among the states in immunization coverage rates of 2 year-old children.

The Division of Immunization Services is working to increase the number of providers who regularly report to the Immunization Registry, the West Virginia Statewide Immunization Information System (WVSIIS). The 385 providers of immunizations enrolled in the Vaccines for Children (VFC) Program have reported at least once to WVSIIS, but only 80-85% report regularly to the Registry. A Certificate of Immunization has been developed.

Meetings are held regularly with HealthCheck program staff to improve outreach efforts regarding immunizations. Currently, staff is working to increase the number of high volume HealthCheck providers who also provide immunization services.

c. Plan for the Coming Year

The Certificate of Immunization will help improve preschool and school-age immunization levels by establishing a standard process by which children are given documents certifying receipt of age-appropriate immunizations. A uniform Certificate of Immunization will enable the consolidation of all valid immunization dates on one document that can be utilized by schools, child care centers and in other settings. The certificate is a tool used by the Division of Immunization Services as an ongoing effort to increase preschool and school immunization levels in West Virginia. VFC providers in WV may now order vaccines online via the WVSIIS. Additionally, providers may manage inventory and generate vaccine usage reports, coverage rates, and reminder/recall messages from the Registry. The WVSIIS has also developed a consent authorization form for public schools to distribute to guardians of new school enterers in the K-12 school system which would authorize the Department of Education to share the immunization records of new school enterers with the WVSIIS database.

Approximately 12,000 mailings were accomplished to emphasize the importance of adolescent immunizations. The HealthCheck Program now conducts targeted outreach to all Medicaid-eligible youth not enrolled in a Managed Care Organization the month of their eleventh birthday. HealthCheck is currently participating in the new statewide "7th grade immunization campaign" with the WV Immunization Program to provide TD or Tdap vaccines in school-based clinics during the fall of 2010.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	19	19	19	19	19
Annual Indicator	20.0	20.9	20.7	23.2	20.8
Numerator	707	739	733	779	700
Denominator	35411	35411	35411	33640	33700
Data Source				2008 Vital Statistics	2008 Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore					

a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	20	19	19	18	18

Notes - 2009
Based upon 2008 Vital Statistics

Notes - 2008
2008 Vital Statistics

Notes - 2007
2007 Vital Statistics

a. Last Year's Accomplishments
The West Virginia Abstinence Education Project:
Provided full curriculum classes to 6,947 students in 19 counties;
Worked with community partners to coordinate 4 regional Teen Expo events;
Promoted the National Campaign to Prevent Teen Pregnancy's National Day event as part of National Teen Pregnancy Prevention Month, distributed National Day items to students attending curriculum classes as well as high school proms and athletic events;
Coordinated Mother-Daughter Retreats and Father-Daughter Date Night events throughout the northern panhandle;
Piloted a peer education mentoring program at Morgantown High School in Monongalia County.
In partnership with the Healthy Families Initiative, hosted a marriage/relationship conference titled Laugh Out Loud at North Bend State Park;
Coordinated a prom gown auction event in Wood County, WV. High school girls were provided with educational presentation and literature during the event;
Partnered with the Healthy Families Initiative to provide a How to Pick a Partner curriculum training for all local grantees in April 2009. Grantees provided the relationship education program to a total of 124 youth in after-school clubs/programs, summer camps, and youth programs throughout their designated regions;
Displayed educational literature at approximately 100 events across the state;
Provided marriage and relationship education services featuring the PREP (Prevention and Relationship Enhancement Program) curriculum in north central West Virginia; and
Last year, served 11,095 students, parents, and community members.

The Adolescent Health Initiative:
Presented Healthy Family Relationships to the Marshall County Mother & Daughter Program;
Facilitated Leadership to Prevent Teen Pregnancy Task Force;
Partnered with the Global AIDS Task Force Team and United Methodist Ministries to host a United Methodist conference;
Participated in the WV Emergency Contraception Initiative;
Developed posters and banners to provide health information to the community and raise awareness about available health resources;
Sponsored a 5 day Teen Institute camp in Romance, WV. The camp is designed to teach middle school youth how to make positive life decisions and avoid risk behaviors;
Hosted the 20th Annual Region VIII Conference entitled "Reviving the Art of Serious Conversation between Parents and Kids";
Presented the teen dating violence play, "Love is not Abuse" in partnership with the Contemporary Youth Arts Company;
Partnered with America's Promise and First Lady Gayle Manchin to provide regional summits to address the problem of high school dropouts;
Partnered with the Raleigh County Family Violence Task Force to receive a Violence Against Women Act grant award of $67,354; and

Offered several presentation workshops across the state to include: Relational Aggression; Helping Youth Thrive: The Power of Developmental Assets; Bringing Forth the Positive Potential of Youth and A Powerful Tool For Positive Change; Ignite Sparks; The Developmental Assets Model & Your Family.

The Adolescent Pregnancy Prevention Initiative:
Provided pregnancy prevention presentations to 8,553 students;
Partnered with public housing authorities to provide contraceptive and pregnancy spacing education;
Implemented evidence-based curriculum, Reducing the Risk, in state Youth Reporting Centers;
Exhibited at community health fairs;
Partnered with area institutions of higher learning to educate participants on available Family Planning services;
Partnered with youth summer camps and teen institutes to teach delaying tactics and refusal skills with regard to risky sexual behaviors;
Partnered with community groups such as Prevention Resource Center and Family Resource Networks to focus activities on teen pregnancy prevention;
Chaired the Leadership for Teen Pregnancy Prevention;
Presented at TRAINING 3/Regional Teen Pregnancy Prevention Leadership meeting in Baltimore, Maryland;
Exhibited at community prevention conference So Sexy, So Soon, prevention conference Sex, Drugs and Rock-n-Roll and statewide prevention conference Share the Vision;
Hosted training opportunity for community prevention specialists and state educators in Reducing the Risk and Wise Guys: Male Responsibility curricula;
Collaborated on creating an "unplanned pregnancy" option for School Financial Education Program game entitled Get a Life that presents students with real-life scenarios that may affect finances;
Hosted National Day to Prevent Teen and Unplanned Pregnancy Events.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Adolescent Pregnancy Prevention Specialists conducted numerous community education and outreach activities on a regional/local level.		X		
2. Conducted 645 school presentations at WV schools and 52 community events.		X		
3. Recognized and promoted "National Teen Pregnancy Prevention Month".			X	
4. Recognized and promoted “Let’s Talk Month”.			X	
5. Free family planning services are available at 156 locations.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Adolescent Health Initiative facilitates educational opportunities for adolescents and other community members on preventing pregnancy, delaying sexual activity and other risk behaviors. Trainings will promote positive decision making and support asset-building targeting both traditional and non-traditional partners. Traditional partners include youth 10-19, parents of youth 10-19, schools and public health/local health departments. Non-traditional partners include local business/industry, health care, and the faith community.

The Adolescent Health Initiative will partner with The Adolescent Pregnancy Prevention Initiative and community-based non-profits to secure evidence-based pregnancy prevention funding for West Virginia.

The Adolescent Pregnancy Prevention Initiative continues to partner with local community groups in order to provide programming that addresses risky adolescent behavior that may result in unplanned pregnancy. Specialists work with community teen institutes and summer camps providing activities such as Mythbusters, a game that counters untrue beliefs about sex that are common among adolescents. Additionally, Specialists are partnering with community groups to plan healthy events that will interest teens and utilize the increased free time of summer. These events include awareness pool parties, self-esteem workshops and responsibility training.

c. Plan for the Coming Year

APPI will continue to provide development, oversight and coordination of educational activities within regional/local communities. An APPI Specialist will incorporate multiple teaching methods and personalize to individual needs. The APPI will continue to conduct community education and outreach activities to increase public awareness of adolescent pregnancy prevention and related issues targeting community groups, schools, health care professionals, and parent groups.

APPI has applied for a federal grant targeting teen pregnancy prevention efforts. The project, Safer Sex-Implementing Health Education for At-Risk Adolescents in the Clinical Setting, will be using the evidenced based program model, Safer Sex, which has been evaluated and proven effective for use with populations similar to West Virginia and is based in a clinical setting. Safer Sex is intended to reduce the incidence of STDs and improve condom use among high-risk female adolescents, which would also result in preventing pregnancy. The components of the program will delivered individually to participants by a health educator within a FPP provider setting, targeting any female adolescent seeking services in the provider site. The project will require expansion of effort and increasing staff from four to nine Specialists.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	33	35	38	30	57
Annual Indicator	33.3	37.5	55.9	56.1	56.6
Numerator	1416	1309	11461	11500	11600
Denominator	4256	3488	20485	20485	20485
Data Source				Health Care Authority	CMS 416
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	57	58	58	59	59

Notes - 2009

Estimate based upon CMS 416 Fiscal Year 2009
(receiving preventive dental services)

Notes - 2008
Previous years not calculated or reported correctly.
Based upon 2006 data from Health Care Authority with Medicaid children with procedure code of D1351 (sealant) by age group.
Denominator from Vital Statistics and US Census.

Notes - 2007
Previous years not calculated or reported correctly.
Based upon 2006 data from Health Care Authority with Medicaid children with procedure code of D1351 (sealant) by age group.
Denominator from Vital Statistics and US Census.

a. Last Year's Accomplishments
The CDP, in partnership with county school systems, Marshall University, Head Start agencies, WIC, 4-H, school-based health centers and other community children's programs, are working together to offer a sealant and fluoride rinse program within schools. Payments from existing insurance sources are sufficient to cover operational costs and ultimately improve oral health access. This project was initially provided only to students in Lincoln County, but the OHP continues to work with its partners to expand this service to students in Mason, Jackson, and Mingo Counties. The OHP continues to provide portable dental equipment to primary care facilities for the purpose of offering school-based dental services in Calhoun, Fayette, Jackson, Lincoln, Marshall, Nicholas, Ohio and Ritchie Counties to include sealant applications. Approximately 53% of children have coverage with Medicaid or WVCHIP, and there are 859 licensed practicing dentists in West Virginia with over 500 serving Medicaid and CHIP patients. Sealants are a covered benefit for Medicaid and CHIP beneficiaries. Every county in West Virginia has a dentist who accepts Medicaid and/or CHIP. There were over 77,000 children who received oral health education and promotion in 2009. West Virginia serves 26,481 in tobacco programs, 21,855 children with dental screenings, 16,328 in the fluoride rinse program, 397 in the fluoride supplement program, 27,215 in the mouth guard/injury prevention program, and 95 children served in the sealant program.

OMCFH administers the Bureau for Children and Families Pre-Employment Services Dental/Vision Project that supports services to assist persons transitioning from Welfare to Work. In FY 2009, $1,305,961 was spent serving 1,926 persons for dental benefits. OMCFH also administers the Donated Dental Project in which dentists donate their time to fit a patient for dentures and is reimbursed for a lab bill up to $500. The Project only has 65 dentists throughout 34 counties, and recruitment for providers is difficult. Funding is limited and can only provide $40,000 per year which means that only 100 persons can be served each year.

The West Virginia Department of Health and Human Resources Oral Health Advisory Board was able to develop the West Virginia Oral Health Plan 2010-2015 which identifies issues and barriers related to oral health in West Virginia. The plan was composed of information received from 10 regional town hall meetings throughout the state where members of the audience were able to identify and discuss oral health issues in their respective regions of the state. The Advisory Board will continue to meet quarterly to work on implementation of the plan and make any amendments or modifications which may arise or be identified.

WV's Governor allocated $1,000,000 in state funds for the purchase of oral health equipment for Primary Care Centers. Currently, there are ten Primary Care Centers which have dental services on site. The OMCFH worked collaboratively with the Division of Primary Care, Deputy Secretary, Deputy Commissioner, and the Chief Executive Officer of the Primary Care Association to develop a competitive grant request for applications, coordinated a grant review committee to review the applications, and made funding recommendations. There were 8 proposals that were

recommended for funding based on scoring criteria and available funds.

The Oral Health Program is working with Marshall University to establish a surveillance system for school based oral health activities. Currently, school based oral health centers serve 61 schools in 24 West Virginia counties.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Children's Dentistry Project (CDP) subgrants preventive health block funds for application of sealants.		X		
2. CDP collaborated with a CHC and a county school system on a pilot project for sealant application.		X		
3. CDP provides oral health education which includes information on sealants.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oral Health Program works in concert with other OMCFH programs, Head Start, and the public school system to promote awareness and availability of oral health services as an integral part of preventive, primary health services through educational instruction. Oral Health efforts are funded from the Preventive Health Block grant, Title V, and State appropriation. The Program conducts needs assessments, provides fiscal resources to local communities to support learning opportunities for children and adolescents which encourage behavioral change; i.e. regular check-ups, brushing/flossing, use of mouth guards during sports activities, and healthy lifestyles through being drug, alcohol, and tobacco free. OMCFH has contracts with local health departments, primary care facilities, and oral health care professionals to provide educational services and materials to all 55 counties in West Virginia. These local health departments and contracted dental hygienists are responsible for oral health education efforts which include working with the public school system. This program also supports fluoridation and sealant efforts in the community, in addition to providing oral health supplies and education materials which are requested from and sent to various partners throughout the state.

c. Plan for the Coming Year

The CDP will continue to work with Valley Health Systems to provide sealants to elementary students in Lincoln County. Plans are being discussed to expand services to other counties. The CDP Coordinator will work with the Early Childcare Services Coordinator to learn what can be done to improve dental health services for children. The CDP will collaborate with the Office of Environmental Health Services in obtaining fluoridation equipment for communities in need for 2010. The CDP will work with oral health partners to develop a standard educational module for oral health educators so that a consistent message will be provided to children and families throughout the state.

The OHP will expand the Oral Health Advisory Board to study policy and processes to improve oral health access and utilization. The Advisory will continue to meet quarterly to assess policy and processes to improve oral health status. The Advisory will review the Oral Health Plan on a

regular basis and address any issues/barriers and incorporate strategies to modify the plan to address the identified topics. The Advisory will establish recommendations for systematic and ongoing monitoring of Medicaid and WVCHIP reimbursement as well as develop a plan to phase in expansion of coverage for children, adults, and pregnant women. The Advisory will define protocol and develop educational components and training opportunities for pediatricians and family practitioners to replicate proven and successful oral health programs.

The OHP will strengthen the state-level infrastructure by searching funding to support staff expansion and implementation of the Oral Health Plan. The OHP will promote and build upon the state surveillance systems to assess the needs and monitor progress in improving oral health. The OHP will sustain a coalition of stakeholders in both public and private sectors in reducing oral health disease by advocating and supporting program and policy improvements, encouraging adequate communication between partners, and increasing public awareness. The OHP will promote oral health across a lifespan by identifying funding to implement a statewide oral health public awareness campaign. The OHP will work to strengthen and improve the oral health workforce, especially in underserved areas by exploring options for recruitment and retention of dentists. The OHP will collaborate with the Department of Education to define the role of the oral health educators to maximize effectiveness and encourage local boards of health to implement a dental health component. The OHP will support and collaborate with oral cancer to study risk factors and improve accessibility of screenings. The OHP will work with West Virginia schools to promote oral health and support expansion and improvement in school-based oral health programs.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3.5	3	3.3	3.9	4.5
Annual Indicator	3.6	4.6	5.4	3.5	3.2
Numerator	12	15	17	11	10
Denominator	329137	329137	316809	316986	317000
Data Source				2008 Vital Statistics	2008 Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3	3	3	3	3

Notes - 2009
Based upon 2008 Vital Statistics

Notes - 2008
2008 Vital Statistics

Notes - 2007

2007 Vital Statistics

a. Last Year's Accomplishments
West Virginia continues to develop traffic safety materi¬als targeted at young people. Through collaboration, the Department of Education's school-based health education is being improved to incorporate information on health-related decision making.

The Charleston Police Department Community Services Division and the Kanawha County Communities that Care have Safety City, McGruff Messages, Click it or Ticket Messages, DUI checkpoints to make sure kids are buckled and assure the car seats are installed properly. In addition to McGruff, Buckle Bear attends events to encourage children to buckle up. Information and promotion items from the National Highway Safety Administration are given out.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Department of Education/Health Education Assessment Project to calculate student health knowledge of seat belts and other safety issues.		X		
2. Adolescent Health Coordinators and others provide classroom injury prevention instruction.		X		
3. The EPSDT Program provides anticipatory guidance to parents regarding childhood injuries.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Adolescent Health Initiative offers parent/child communication skill building, community development activities that include plans for safe recreation after prom, etc. Helping families to talk with their children about risk behaviors is an essential part of affecting change.

The EPSDT Program continues to provide anticipatory guidance to parents about childhood injury that may result in death. The Adolescent Health Initiative also develops teaching tools which encourage the use of helmets as a means of preventing traumatic brain injury. At the time of discharge, all birthing hospitals in the state issue an infant car seat for those families who do not have/can't afford one. The Adolescent Health Initiative was designed to complement the HealthCheck Program with the express purpose of creating awareness among families and others of the need for young persons between the ages of 10 and 17 to be provided routine health services. This program includes: 1) the provision of educational programs emphasizing preventive services/risk reduction behaviors such as seat belt use and tobacco/alcohol use; and 2) development of teaching modules that can be used in community-based training designed to improve the health and well-being of adolescents and their families.

c. Plan for the Coming Year
Work continues with the Transportation and Traffic Safety Division to develop materials that are directed to youth. We also use our existing workforce and partnership network for distribution of this anticipatory guidance.

Partnerships continue to support the Department of Education efforts to improve health education instruction in public schools designed to positively affect health and health related decision making.

The Division of Highways will lead the development of implementation plans to execute the initiatives in the Strategic Highway Safety Plan. While extenisve work is currently underway to implement many initiatives outlined in the Plan, a coordinated effort continues to devise both emphasis area implementation plans and an overall detailed management plan for the Strategic Highway Safety Plan.

To be effective, a plan cannot rest upon a shelf. It must be refined over time to address changing conditions. The Strategic Highway Safety Plan is viewed as a dynamic document and will continue to evolve as West Virgina evaluates its outcomes.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		35	35	60	35
Annual Indicator	32.0	56.0	32.5	34.0	35.0
Numerator	6700	11730	7155	7310	7700
Denominator	20920	20931	22017	21492	22000
Data Source				2008 PRAMS	2008 PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	35	35	40	40	40

Notes - 2009
based upon 2008 PRAMS - mom breastfeeding at 8 weeks

Notes - 2008
2008 PRAMS data - mom breastfeeding at 8 weeks

Notes - 2007
2007 PRAMS data - mom breastfeeding at 8 weeks

a. Last Year's Accomplishments
While the latest data on breastfeeding indicates that a low percentage of women choose to breastfeed their infants, this should not be taken as an indication of little effort on the part of the State's Bureau for Public Health or, in particular, the Office of Maternal, Child and Family Health (OMCFH). All pregnant women participating in the RFTS Project receive information about the benefits of breastfeeding their infants. RFTS Project DCCs provide comprehensive in-home breastfeeding education and support to prenatal participants through sixty days postpartum and

to breastfeeding mothers of eligible infants until their infant reaches age one year.

Educational tools such as videos, DVDs, brochures, The Pregnancy Workshop and medical models were available to RFTS DCCs for use on home visits to promote breastfeeding. A DVD player was used by each RFTS DCC in order to more effectively provide client education in their homes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The WIC Program strongly supports and promotes breastfeeding.		X		
2. WIC goals include providing additional funds to local agencies that will allow breastfeeding peer counselors to visit local hospitals and physicians' practices in order to keep mothers breastfeeding longer.				X
3. WIC increased income guidelines to allow more women, infants and children to qualify.				X
4. RFTS collects data on prenatals who are breastfeeding at hospital discharge, and how many continue to breastfeed at case closure.				X
5. All women participants in the RFTS receive benefits of breastfeeding information.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Pregnant RFTS Project participants are encouraged to breastfeed and educated on health and socioeconomic benefits such as how human milk meets the specific needs of human babies and changes with growth to offer the best combination of nutrients.

Women are educated about the health benefits for themselves associated with breastfeeding including reduction of postpartum blood loss, increased postpartum weight loss with no return of weight once weaning occurs, possible delay of fertility, need for reduced insulin in diabetic mothers, psychological benefits of increased self-confidence and enhanced mother/infant bonding, reduced risk of breast, ovarian and endometrial cancers, reduced risk of osteoporosis and bone fracture.

The social and economic benefits of breastfeeding for families are emphasized by RFTS Project DCCs such as saving several hundred dollars when the cost of breastfeeding is compared to the cost of using formula. Breastfeeding is convenient and safer because breast milk is always available at the correct temperature, is sterile, and requires no mixing.

The RFTS Project encourages collaboration with WIC offices statewide to ensure participants continue to receive breastfeeding education and support after case closure. In 2009, the Project continued active involvement with WV WIC in a collaborative strategic planning effort to develop a cross-referral system for service integration and coordination.

c. Plan for the Coming Year

The RFTS Project will continue to provide educational materials on breastfeeding such as videos, pamphlets, and literature for DCCs to use during home visits. RFTS DCCs promote breastfeeding with each prenatal participant and provide support and referrals as needed. RFTS will continue to train DCCs on the benefits of breastfeeding and how to encourage participants to try breastfeeding as their choice for infant feeding.

RFTS DCCs have access to the use of standardized step-by-step prenatal curriculum which includes education on breastfeeding. The curriculum is entitled "The Pregnancy Workshop" and "Planning A Healthy Pregnancy" and is available to each DCC at no cost.

RFTS is committed to increasing breastfeeding rates throughout WV and promoting optimal breastfeeding practices. This goal can be achieved through the existing RFTS Project network by supporting breastfeeding mothers, their families, communities, employers, and health care providers by providing education, training, funding, technical assistance, and research.

Women can be encouraged to breastfeed longer into the postpartum period by being educated to seek assistance from local support groups, other mothers who have successfully breastfed and from their local WIC lactation consultants.

The Director of Perinatal Programs and the RFTS RCCs will continue collaborative efforts with staff of the WV Office of Nutrition Services to ensure that local WIC offices refer clients to the RFTS Project and work effectively with DCCs.

Since each RFTS Project DCC is now assigned a DVD player to use for client/family education during home visits, the Project is using recently purchased educational DVDs that effectively promote breastfeeding. Copies of the DVD entitled "The Baby Care Home Video" in English and Spanish were purchased by the OMCFH and assigned to each DCC for use during in home education and included information on how to successfully breastfeed.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98.5	99	99	99	99
Annual Indicator	93.7	91.9	94.7	99.0	96.1
Numerator	19526	19431	20843	21233	20461
Denominator	20834	21137	22017	21443	21299
Data Source				Birth Score Office	Birth Score Office
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	99.1	99.2	99.2	99.3	99.3

Notes - 2009

numerator: 2009 WVU Birth Score Data - occurrence births screened before hospital discharge
denominator: preliminary 2009 occurrence births

Notes - 2008
2008 WVU Birth Score Data - occurrence births screened before hospital discharge

Notes - 2007
2007 WVU Birth Score Data - infants screened before hospital discharge

a. Last Year's Accomplishments
Interlacing Birth Score and NHS follow-up information has significantly reduced the risk of human error as well as time involved in completing forms with duplicate information. The BSO, NHS and Vital Statistics staff continued to discuss the BSO receiving timely, current birth information to identify those infants for whom a Birth Score card had not been completed, and identify hearing screen data.

The entire referral and follow-up process has been streamlined and allows the database to serve as a monitoring tool for quick reporting on specific practitioner performances. This helps assure project protocols are completed, as well as provides information to the NHS Project.

West Virginia birthing facilities continue to be concerned with the number of newborn hearing screens and Birth Score cards not being completed before discharge and provide opportunities to screen infants who are missed after discharge. Equipment failure at birthing facilities is a common reason cited for missed screens and prompted the use of NHS Project money to purchase loaner equipment. Loaner machines have been used in several instances throughout the year, helping to continue hearing screening before discharge and reduce the number of referrals made to RFTS for follow-up.

Kids First Hearing Project provided services for 49 children. To date, $94,481.12 has been used to provide hearing aids, hearing evaluations, ear molds, warranties and hearing aid batteries to WV children who would not otherwise have access to these services. The Project has also encumbered an additional $30,927.98 for services yet to be rendered.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All WV birthing facilities are required to screen infants for hearing loss before discharge.			X	
2. Infants identified with a hearing loss are referred to the CSHCN Program for assistive devices.		X		
3. OMCFH purchased and maintains diagnostic equipment to assure access/availability as loaner equipment and shared hospital equipment.				X
4. Redesigned and updated NHS website.				X
5. Educational literature is created and distributed to providers and parents.		X		
6. Maintain Advisory Board members per WV state code.				X
7.				
8.				
9.				
10.				

b. Current Activities

The NHS Project continues to focus on improving access to timely audiological diagnosis and intervention. Birthing hospitals continue to be provided with NHS information and education from the Birth Score Office. Audiological service availability and resource guides are disseminated to providers, audiologists and community agencies by the NHS Project in order to assure that infants and their families are directed to appropriate hearing evaluation and intervention as quickly as possible and informational brochures in both English and Spanish, continue to be distributed through community health fairs and other events statewide.

Continued efforts are being aimed at cleaning the database and outlining processes, as well as improving database usefulness as an oversight tool to provide the most current, detailed information to regional staff for the timeliest follow up for infants and their families.

The eight region Right From The Start workforce continues to follow-up with families of infants who initially missed or failed screens, through direct referral from the Birth Score Office. In May 2009, a two day workshop was held in Charleston for RFTS covering many topics relevant to interviewing clients, engaging clients in providing services and documenting progress reporting.

c. Plan for the Coming Year

The first goal of the NHS Project is to make sure 100% of newborns born in WV are screened for hearing loss prior to discharge from a birthing facility or within the first month of age. All 33 birthing facilities have a minimum of 2 trained staff with competence in screening and referral protocols. Border hospitals will continue to refer WV newborns to the BSO where 100% of not screened/failed infants will be tracked and referred for follow-up.
West Virginia resident infants born at home will receive follow-up for screening and referral for audiological services if indicated.

The second goal of the NHS Project is to insure all infants requiring audiological follow-up and/or intervention receive diagnostic evaluation by 3 months of age and receive intervention services by 6 months of age if necessary. The NHS Advisory Committee, NHS Project Coordinator and RFTS will explore options for a pilot project enabling clients to receive screening at a facility close to their residences in order to minimize lost to follow-up for those infants who have not been rescreened because of the inability to return to a convenient site. The NHS Project will make improvements to the follow-up process to assure appropriate, timely audiological evaluation and intervention.

The third goal of the NHS Project is to continue to improve and assess resources to ensure 100% of children with hearing loss and their families are linked to community-based, culturally competent support systems including early intervention and parent-to-parent networks. The Audiology Service Availability Guide will be updated annually and a web-based resource directory will be maintained.

The fourth goal of the NHS Project is to provide monitoring, project evaluation and quality assurance data reports to all stakeholders. The NHS Data Manager and Project Coordinator will produce comprehensive data reports and conduct program monitoring and evaluation quarterly and annually.

The NHS Project will continue to research and implement specific strategies aimed at reducing the number of WV infants and families who are lost to identification and follow-up care. In an effort to contact families and reduce loss to follow-up in 2010-2011, RFTS will continue to mail an introductory letter and brochures outlining NHS and RFTS services to families when no other contact information can be obtained.

In 2010-2011, each birthing facility will again be requested to validate contact personnel and identify issues/concerns with the screening and referral process. As in 2009, NHS staff, RFTS

and the BSO will conduct annual or as needed site visits to the hospitals to discuss compliance issues and review reporting/referral protocols.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	4	5.7	4.3	4.2
Annual Indicator	5.8	5.7	4.5	4.5	5.0
Numerator	24664	24500	19057	19057	21300
Denominator	427879	427879	427879	427879	427879
Data Source				2008 CHIP Annual Report	2009 CHIP Annual Report
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4.5	4.5	4	4	3.5

Notes - 2009
Note 1: The most recent estimate for all uninsured children statewide from the U.S. Census Current Population Survey is from 6.3% to 5%. Even a five percent extrapolation at the county level may vary significantly from county to county depending on the availability of employee sponsored insurance. However, it remains our best gross estimate of the remaining uninsured children.
Note 2: It has been estimated that 7 of 10 uninsured children qualify or may have qualified for CHIP or Medicaid in the past, WVCHIP uses the lower estimated limit of 5% as a target number for outreach due to the way census sampling is likely to overstate this rate.

Notes - 2008
2008 CHIP Annual Report - data for fiscal year ended June 30, 2008

Notes - 2007
2007 CHIP Annual Report - data for fiscal year ended June 30, 2007

a. Last Year's Accomplishments
During the 2006 Legislative session, House Bill 4021 passed authorizing WVCHIP to adopt a higher income limit of 300% for program eligibility. In implementing this legislation, the Board adopted premium payments for those children with family incomes above 200%FPL. The Bill also extended the "waiting period" for children to be uninsured, from the six-month requirement for the regular WVCHIP program, to twelve months for children eligible under the expanded program. After much deliberation, the Board, at the request of the Governor, adopted a higher income limit of 220%, with planned annual expansions in 20% increments, until the full 300% limit is adopted. On January 1, 2007, WVCHIP implemented the higher income limit for program eligibility of 220%FPL. This expanded program was named WVCHIP Premium. In addition, the Board approved a full medical and drug benefit package, with higher co-payments, a limited dental

package, and no vision coverage.

Following the Public Employees' Insurance Agency's lead, WVCHIP adopted a voluntary medical home program for its members on March 1, 2007. Under this program, members agree to utilize one physician for all their primary care needs selected from a directory of qualified physicians specializing mostly in pediatric or family medicine. In exchange, co-payments for all visits to a member's designated medical home are waived. Providers receive full payment for services from WVCHIP.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State leaders promote SCHIP and increasing enrollment.				X
2. Currently, WVCHIP's elgibility is 220% FPL. This will increase by 20% a year until 300% is achieved.		X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Governor Manchin charged an interdepartmental team with working on a goal of assuring that every child starts school healthy and ready to learn. In an initiative called Kids First, the strategy to reach this goal is to assure that every child has an opportunity for a comprehensive wellness screen by a physician prior to entering kindergarten. WVCHIP played a key part in this initiative seeking approval of State Plan changes that would permit the program to reimburse providers rendering wellness screens to uninsured children as a special public health or preventive measure. Since West Virginia now has health coverage in a public or private form for 95% of its children, federal approval would mean that the remaining 5% with no insurance (or about 1,100 children of kindergarten age) could receive such a wellness screen.

The Director of the OMCFH has been an active member of the Governor's planning committee for the Kids First Initiative.

CHIP has partnered with clinics across the state encouraging them to distribute applications for CHIP. The WV Primary Care Association received fiscal support to provide community-based outreach for CHIP statewide.

The Pediatric Program Specialists, as a part of EPSDT, administered by OMCFH, routinely distribute CHIP applications when visiting medical practioner sites serving children.

Medicaid has no plans for eligibility expansions, so SCHIP is the sole source available for financing health care for medically indigent WV children.

c. Plan for the Coming Year

West Virginia has become one of the most successful states in enrolling children in CHIP and Medicaid. More than 95% of the state's children now have health coverage. The increase in enrollment of children in both CHIP and Medicaid has been the result, in part, of the efforts of a

public/private partnership between the WV Healthy Kids Coalition, primary care centers, Family Resource Networks, state government, and private and public funds. For the last four years, the WV Healthy Kids Coalition has conducted community-based outreach for CHIP and Medicaid through the placement of outreach coordinators who serve each of the state's 55 counties from 49 locations. Since the inception of this program, more than 40,000 children have been enrolled in CHIP and more than 5,000 children have been enrolled in Medicaid via the CHIP application. To maintain and even improve upon this high level of enrollment we must continue this effective outreach and enrollment effort and explore the recommendations from advocate groups for affordable health coverage.

Given the above, our issues are assuring that the state has sufficient medical capacity to meet the demand and secondly, creating a demand for care by educating would-be consumers on the importance of receiving basic primary, preventive health care. In order to determine why patients aren't using the health services now that they have health care financing, we plan to survey families and providers about issues of accessing care.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		25	24	23	25
Annual Indicator	27.2	25.0	24.0	27.4	28.1
Numerator	6488	5899	4938	5169	5407
Denominator	23861	23611	20556	18835	19266
Data Source				2008 WIC Data	2009 WIC Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	28	27	26	25	25

Notes - 2009
2009 WIC data

Notes - 2008
2008 WIC data

Notes - 2007
2007 WIC data

a. Last Year's Accomplishments
The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) began offering new, healthy food choices on October 1, 2009. Women, infants and young children participating in the program receive a variety of healthier foods, including fresh fruits and vegetables, whole grain products such as bread and cereal, jarred baby foods, and soy

beverages.

Since 1974, WIC has combated childhood hunger, low birth weight, under-nutrition, and iron deficiency anemia so that WIC participants have better health outcomes. However, new dietary recommendations to eat less fat, more fiber, fewer overall calories, fewer sweetened beverages and more vegetables and fruits as well as changes in the factors affecting the health of women, infants and children prompted a review of the foods provided by WIC.

The new foods provided by the West Virginia WIC program follow changes issued by the USDA's Food and Nutrition Service. It largely reflects recommendations made by the Institute of Medicine (IOM) of the National Academies in the final report of its analysis of the WIC food packages, WIC Food Packages: Time for a Change, as well as the latest nutrition science and the 2005 Dietary Guidelines for Americans. The new choices also encourage breastfeeding and support infant feeding practices recommended by the American Academy of Pediatrics.

WIC provides pregnant, breastfeeding, and postpartum women, infants, and children up until their fifth birthday with nutritious supplemental foods. The program also provides nutrition education and referrals to health and social services. More than 52,000 West Virginia participants receive WIC benefits each month, with a federal investment of over $48 million in FFY 2009. WIC food packages were first designed in 1974 to supplement participants' diets with foods rich in five nutrients-vitamins A and C, calcium, iron, and protein-because those nutrients were lacking in the diets of the WIC target population. The WIC program has long been considered one of the most successful federal health programs.

All local WIC agencies are engaging in grassroots marketing and completing at least 102 hours of outreach in their local communities. This has resulted in increased program access with 2.5% statewide caseload growth through 2009. The WIC program served an average of 52,497 people each month and contributed $38.8 million to the WV economy through food purchases.

The Farmer's Market Nutrition Program has continued to grow through the WIC program with 52 counties participating through 33 WIC sites. Redemption rates grew to 72% in 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WIC supports healthy nutrition and breastfeeding.	X			
2. WIC increased income guidelines to allow more women, infants and children to qualify.				X
3. 23% of the WIC Budget is dedicated to nutrional education.		X		
4. 1. Since 1974, WIC has combated childhood hunger, low birth weight, under-nutrition, and iron deficiency anemia so that WIC participants have better health outcomes.		X		
5. 2. The new WIC food choices encourage breastfeeding and support infant feeding practices recommended by the American Academy of Pediatrics.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

West Virginia's new food package rollout, Sesame Street's Healthy Habits for Life multimedia outreach kits, are distributed to WIC families. The kit consists of an original DVD and storybook starring the Sesame Street Muppets, featuring "The Get Healthy Now Show" that encourages children with the help of their friends, to explore ways to eat and drink so they can play, learn, and grow up healthy. It also includes a guide for parents and caregivers that contains strategies and hands-on activities for everyday and on the go.

The WV WIC program has developed and implemented online nutrition education. The purpose of the website is to help WIC participants learn more about feeding their child such as providing regular meals and snacks, working with picky eaters, creating a positive eating environment, and the roles of the parent and the child in the feeding relationship.

c. Plan for the Coming Year

WIC participants receive individual and group nutrition education, breastfeeding support, referrals to health care providers, assistance with making healthy lifestyle choices, and help with immunizations. The Special Supplemental Nutrition Program for Women, Infants and Children provides participants with certain healthy foods for free, and offers assistance in planning low-cost healthy meals that include foods high in essential nutrients and vitamins.

State staff have started training local agency vendor liaisons, community outreach liaisons, nutritionists and outreach coordinators through face-to-face visits to authorized vendors. The training and technical assistance have the goal of developing a store specific product list that serves as a reference for cashiers and a participant education tool. In addition, shelf tagging while simultaneously correcting the store computer system offers the ability to facilitate change quickly. This method also allows a direct, hands-on teaching approach for vendors as well as WIC staff in gaining understanding in how the shopping experience can be overwhelming to WIC participants.

The State Head Start Collaborative Director and WV WIC Outreach Coordinator are meeting to revise the Memorandum of Understanding implemented in 1997 to define statewide specific referral procedures that will occur two times per year for service coordination, integration and access.

The United States Department of Agriculture, Food and Nutrition Service has awarded an Electronic Benefit Transfer (EBT) planning grant to Virginia to conduct a feasibility and implementation study for the WIC program in Virginia and West Virginia. Currently a data collection tool is being developed for EBT cost evaluation.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		25	27	26	26
Annual Indicator	25.3	29.0	30.0	28.7	28.2
Numerator	5225	6075	6595	6165	6000
Denominator	20630	20931	22017	21492	21299
Data Source				2008 PRAMS	2008 PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	28	27	26	25	25

Notes - 2009
Based upon 2008 PRAMS and preliminary 2009 births

Notes - 2008
2008 PRAMS data

Notes - 2007
2007 PRAMS data

a. Last Year's Accomplishments
WV has one of the highest smoking rates for pregnant women in the United States. 2008 data from the WV Health Statistics Center show that the rate of smoking during pregnancy in WV was 27.5% compared to the National rate of 10.7% in 2005 (last available national information). Alarmingly 40.7% of the Medicaid insured mothers smoked during pregnancy. 11.7% of the non-Medicaid insured women in West Virginia reported smoking during pregnancy. Data collected by the RFTS in 2008 showed 38% of pregnant participants were self reported smokers. In response, WV continued to provide SCRIPT services, the intensive smoking cessation initiative.

Educational tools such as videos, Carbon Monoxide Breathalyzers, smoking cessation guides and smoking cessation incentives were available for use during home visits. Additional Carbon Monoxide Breathalyzers and supplies along with smoking cessation DVDs, guides and literature were purchased using WV Division of Tobacco Prevention funding in 2009. A portable DVD player is assigned to each DCC to use to provide more effective client education during home visits.

The SCRIPT Coordinator facilitated the SCRIPT OB-MD/RN Advisory Committee Meeting in July and four meetings of the SCRIPT Program Management Committee (PMC) during 2009. SCRIPT in-service/updates were provided at least one time to each of the eight regions during 2009 by the Coordinator.

RFTS utilizes three forms to collect client smoking information; the Tobacco Screening, SCRIPT Intervention and Follow-up Forms. Data from these forms are entered into the RFTS Electronic Data System (EDS). An additional data quality assurance review began in July 2009. The WV SCRIPT Coordinator and GWU Research Assistant began completing quarterly SCRIPT data resolution to assure accurate SCRIPT data collection in both the RFTS EDS and the GWU Teleform System.

During 2008 the RFTS SCRIPT Program enhanced collaboration with the WV Division of Tobacco Prevention and the WV Tobacco Quitline to increase Quitline referral, utilization and ultimately, cessation outcomes. In 2008 the WV Tobacco Quitline enrolled 4,367 participants; one hundred thirty-one of these participants were pregnant women. The majority of these enrolled pregnant women, one hundred three were Medicaid insured (78.6%).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented the Smoking Cessation Program developed by Dr. Richard Windsor in January, 2002 and is ongoing. (SCRIPT)				X
2. The WV 'SCRIPT' uses the existing home visitation network and protocols in the RFTS Project.		X		
3. Information about negative effects of smoking during pregnancy is distributed to all women.			X	
4. SCRIPT provided to all willing RFTS/HAPI participants.		X		
5. Information collected in OMCFH Research Division's Tobacco Screening databases.				X
6. All RFTS smokers/former smokers are offered CO Testing.		X		
7. State government maintains Tobacco Quit Line.				X
8.				
9.				
10.				

b. Current Activities

The RFTS SCRIPT Program continues to provide education to participating providers statewide. All RFTS Regional Care Coordinators (RCCs) receive monthly training and updates and then provide quarterly mandatory group and/or individual training sessions to DCCs. The SCRIPT Coordinator continues to attend regional DCC trainings to provide SCRIPT Program updates.

The virtual training CD, "Smoking Cessation for Pregnancy and Beyond-Learn Proven Strategies to Help Your Patients Quit", continues to be used as part of the training curriculum, for both new and existing DCCs.

The RFTS Project continues to work closely with the WV Division Of Tobacco Prevention and WV Tobacco Quitline. All pregnant women that are smoking are provided with information regarding services through the Quitline. Referrals are completed by the DCCs for any RFTS client requesting Quitline services. The Quitline may be used in conjunction with RFTS services if the pregnant woman chooses both interventions.

c. Plan for the Coming Year

The foundation has been laid in WV for an effective statewide initiative to continue reductions in the number of pregnant smokers. Although the RFTS SCRIPT provides smoking cessation education to numerous low income pregnant women and their families, more than half of WV pregnant women are eligible for this support and for public assistance.

The RFTS Project plans to continue to provide smoking cessation education and support to pregnant women and their families on the dangers of smoking during pregnancy and the importance of maintaining a smoke free environment. Providers will continue to use the 5 A's best practice method and a carbon monoxide monitor to provide a visual message of the dangers of smoking during pregnancy.

Dr. Richard Windsor, MS, PhD, MPH, Professor, Department of Prevention and Community Health, School of Public Health and Health Services, George Washington University Medical Center, Washington, D.C., continues to serve as the Principal Investigator for the grant funding provided by the National Cancer Institute for 2007-2011. The George Washington University Institutional Review Board has approved the project and will use West Virginia RFTS as a model of an entire system of care for evidenced based interventions for pregnant Medicaid smokers. One of the primary objectives of the grant is to institutionalize the intervention with staff during/after the grant and evaluation is completed.

The grant will continue to provide funding for the RFTS Project's full-time, SCRIPT Coordinator and a part-time data support person to coordinate the expanded smoking cessation in pregnancy initiative.
RFTS DCCs will continue to receive education on the proper use of SCRIPT resources and service delivery methods to enhance, support and facilitate therapeutic relationships between providers and RFTS mothers desiring to quit or reduce smoking.

Ongoing research continues for new smoking cessation and environmental tobacco smoke exposure educational materials and resources for use in the Project. Informational brochures, specific to the SCRIPT Program, will be developed for clients and obstetricians. New Carbon Monoxide Breathalyzers and accessories will be purchased in the upcoming year to replace older CO units.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	5	7	7.5	6.5
Annual Indicator	8.0	11.1	7.7	9.4	8.6
Numerator	10	14	9	11	10
Denominator	125578	125578	117478	116745	116750
Data Source				2008 Vital Statistics	2008 Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8	7	6	6	6

Notes - 2009
Based upon 2008 Vital Statistics

Notes - 2008
2008 Vital Statistics

Notes - 2007
2007 Vital Statistics

a. Last Year's Accomplishments
While suicide was the 12th leading cause of death overall in West Virginia, it was the third leading cause of death for ages 15-34. The number of suicides among persons aged 19 and under was nine in 2008, same as 2007.

The West Virginia Council for the Prevention of Suicide provides statewide suicide prevention

services through the National Suicide Prevention Lifeline, 1-800-273-TALK. Based upon the severity of the call, emergency dispatchers may be notified, callers may be referred for inpatient treatment, referred for outpatient treatment, or provided with supportive counseling over the telephone.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The OMCFH's Adolescent Health Initiative provides community based skill building opportunities regarding adolescent at-risk behaviors.		X		
2. The EPSDT screen contains a behavior assessment instrument used for age 10 and above.				X
3. The WV Council for the Prevention of Suicide is offering workshops across the state on how to recognize the early signs of depression.				X
4. The Council has completed a five year strategic plan for suicide prevention in WV.				X
5. The Council has had 4 suicide assessment instruments published in the book "Innovations in Clinical Practice".		X		X
6. Adolescent Health Initiative offers worshops on parent-child communication.		X		
7.				
8.				
9.				
10.				

b. Current Activities

The West Virginia Council for the Prevention of Suicide believes education and prevention will assist our state in saving lives of our citizens. Knowing the early signs of depression and suicidal behaviors is paramount in saving someone from their first suicide attempt. The West Virginia Council for the Prevention of Suicide workshops will inform the workshop participants on how to recognize the early signs of depression and then where to go for assistance. The workshops will also explain the early signs of suicidal behaviors and again where to go for assistance. The Council also gives out crisis numbers for every county in West Virginia which has a provider that operates 24 hours, 7 days a week crisis lines.

c. Plan for the Coming Year

The West Virginia Council for the Prevention of Suicide will work to reduce the stigma associated with seeking and receiving mental health services, reduce access to lethal means, provide support to suicide survivors, promote support for suicide prevention among providers, and improve public awareness and understanding of suicide.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	85	98	98	98	90
Annual Indicator	97.3	84.9	82.9	85.0	91.7

Numerator	250	258	248	256	275
Denominator	257	304	299	301	300
Data Source				2008 Vital Statistics	2008 Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	92	92	93	95	95

Notes - 2009
Based upon 2008 Vital Statistics - calculated only on WV residents born in state facilities

Notes - 2008
2008 Vital Statistics - calculated only on WV residents born in state facilities

Notes - 2007
2007 Vital Statistics - calculated only on WV residents born in state facilities

a. Last Year's Accomplishments
The Perinatal Partnership found that many providers, especially at small rural hospitals, complained that pregnant women and/or their newborn infants needing tertiary care were being turned away due to a lack of bed capacity at the three tertiary care centers in the state. Further study demonstrated this to be true and that the Neonatal Intensive Care (NICU) facilities have been functioning at 100 percent capacity. Physicians with the tertiary care facilities reported that they were turning away both high-risk maternal transports and infant transports, primarily due to no availability of NICU beds.

The Partnership's Committee on Adequacy of NICU Beds recognizes that the cost to operate NICU beds and the physical capacity of some tertiary facilities to add more beds poses problems. At the same time, it is of utmost importance to care for newborns as close to home as possible and it was recommended that the tertiary care facilities seriously study their capability to increase NICU beds. To assist in accomplishing this, it was recommended that the WV Health Care Authority should immediately evaluate and update the current methodology utilized in determining Certificate of Need approval of NICU beds. The need to upgrade some community hospitals and equip them to handle newborns needing added care but not necessarily needing transfer to a NICU was discussed. Also, community hospitals can be upgraded to handle NICU "back referrals" for infants needing intermediate but not intensive care. Community hospitals that have the capacity or are willing to upgrade their capacity to accommodate infants that need added care as they transition into health are asked to begin addressing this issue.

During 2007-08, the WV Health Care Authority approved the addition of NICU beds at both WVU-Morgantown Hospitals, and Cabell Huntington Hospital, increasing the availability by twenty-nine (29) beds. No request for additional beds was made by CAMC Women and Children's as their physical capacity does not allow for an increase.

Perinatal providers have long seen a need for easy-to-get, current information about bed availability in WV NICU and maternal high-risk units. Plans are underway to satisfy that need.

The Perinatal Partnership noted that to avoid unnecessary admissions to NICU, each birthing facility and all maternity providers should curtail elective delivery prior to 39 weeks gestation thus

implementing ACOG recommended guidelines for elective delivery. In 2008 an OB Quality Initiative (QI), a project of WV Health Care Authority, WV Perinatal Partnership, and WV March of Dimes began to reduce elective deliveries (both inductions and c-sections).

In 2009, fifteen WV hospitals met to study the frequency of labor induction among first-time mothers, both in cases with and without preexisting medical complications.

The Perinatal Partnership collaborated with the WV Health Care Authority and the March of Dimes to conduct the Obstetrical Collaborative Quality Initiative to reduce elective deliveries prior to 39 weeks gestation. The Partnership identified the frequency of C-section among first-time mothers at 31.9% of all births for 2001-2005. This rate steadily increased from 27.4% in 2001 to 34.6% in 2005. For first-time mothers, the rate of labor induction for the same time period was 37.5%. For all WV resident mothers the rate of cesarean section has continued to rise, from 26.7% in 2000 to 34% in 2005. According to CDC, in 2004, WV had the third highest rate of cesarean sections in the country. Recommendations were developed for elective labor induction to occur only after 39 weeks gestation.

In 2009, RFTS and the WV Chapter of the March of Dimes collaborated in an initiative to distribute educational brochures to obstetrical providers statewide on the importance of allowing a pregnancy to go to term. The brochures encouraged providers to wait until at least 39 weeks to induce labor or perform a C-section unless medical problems make it necessary to deliver the baby earlier. RFTS RCCs hand delivered copies of the brochures to each obstetrical practice as they made their routine office visits.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. OMCFH advocates that all pregnant women be screened for medical risk conditions so that high risk patient care can be planned.				X
2. OMCFH fiscally supports training teams to encourage early screening and referral.				X
3. RFTS protocols support high risk patient deliveries at tertiary care.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Eight (8) RFTS RCCs make regular visits to OB and pediatric providers in each region to recruit providers to assure WV high risk pregnant women and infants have access to early and adequate health care.

In a collaborative effort between the WV Birth Score Program and the WV RFTS Project, informational postcards were developed for use at birthing facilities. These postcards are targeted towards infants who were identified at birth as both High Birth Score and WV Medicaid eligible to help parents understand who may be contacting them to offer RFTS services. Hospitals will include this postcard with the copy of the High Birth Score form that is given to the infant's guardian(s). This will provide an opportunity for parents/guardians to ask any questions

and help them feel more comfortable knowing RFTS will offer support services once the infant returns home.

c. Plan for the Coming Year

The WV Perinatal Partnership is collaborating with the WV State Trauma and Emergency Medical System to make a hotline available that perinatal providers can call to get current information, thereby saving precious time if the provider's usual referral center is not accepting transports. Callers to the hotline can not only find a bed but also be connected immediately with a specialist at the referral center for immediate consultation. The target date for activating the hotline is July 31, 2010.

The Project DCCs and RCCs will continue to screen participants for risks that could result in poor birth outcomes such as preterm and low birth weight births. The DCCs will provide intervention and referral to community resources as needed for issues such as access to care, depression, smoking, use of harmful substances, and domestic violence. Issues affecting each client will be shared with the medical provider using the service care plan which will be updated on a regular basis.

In addition to providing parents with more education about the Birth Score in the hospital, the Birth Score Program is developing a display to be used in community settings (baby showers, conferences, etc.) where mothers may be present. Ideally, mothers will be educated about the Birth Score during their pregnancy so they are prepared to understand their infant's score at birth.

The WV Birth Score Program, WV Office of Vital Statistics and The RFTS Project Electronic Data System currently match and share data on birth outcomes. This will allow the RFTS Project to identify areas of the State which need additional education and intervention through home visiting care coordination services in order to improve birth outcomes.

The Birth Score Program plans to deliver education about the Birth Score at statewide community events to increase understanding and awareness about available services for the infant.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88	89	89	90	90
Annual Indicator	85.0	83.6	82.0	79.1	82.2
Numerator	17700	17500	18060	17001	17500
Denominator	20834	20931	22017	21492	21299
Data Source				2008 Vital Statistics	2008 Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2010	2011	2012	2013	2014
Annual Performance Objective	83	84	86	88	90

Notes - 2009
Based upon 2008 Vital Statistics and preliminary 2009 births

Notes - 2008
2008 Vital Statistics

Notes - 2007
2007 Vital Statistics

a. Last Year's Accomplishments
Since the RFTS Project was first initiated in 1989 and because of this strong network, West Virginia's access to first trimester prenatal care rate has improved from 60-70% in the 1980s to 80.8% in 2008.

In 2009, HB 2837 established an advisory council within the WV DHHR, Office of Maternal, Child and Family Health to provide the Office with assistance in the development of a uniform maternal risk screening tool. The WV Maternal Risk Screening Advisory Committee recommended adoption of the Prenatal Risk Screening Instrument (PRSI). The PRSI includes both medical history and psychosocial information to assess risk. The Committee recommended (1) the PRSI, a screening instrument unique to WV and not copyrighted, can be used statewide without significant cost investment; (2) the PRSI is one page and not burdensome for the medical practitioner or other office staff; (3) the PRSI, as evidenced by the survey, already enjoys widespread acceptance and use; (4) because the form is homegrown, there is the option to modify it; (5) modifications to the form can, in time, be a result of data gathering, analysis and evaluation to better reflect WV's need and patient risks.

Once developed, all health care providers offering maternity services will be required to utilize the tool in their examinations of any pregnant woman, maintain confidentiality and notify the woman of any high-risk condition which they identify along with any necessary referral.

In 2009 providers submitted 7,496 completed PRSIs to the RFTS Project as referrals for pregnant women who were potentially eligible to receive targeted case management services. Data collected from the PRSIs reveal 72% of the women accessed first trimester prenatal care, an increase from 70.5% in 2008.

Once the PRSI is received by the RFTS Regional Care Coordinator, the client is referred to a DCC in the local community immediately for the initiation of care coordination services which includes assistance with access to early and adequate prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Free pregnancy testing is available at sites statewide.			X	
2. Women who have a positive pregnancy test are assisted with securing health care coverage.		X		
3. Adolescents age 19 years and under are automatically eligible for OMCFH financial assistance under RFTS.		X		
4. Early prenatal care is strongly encouraged and supported through all family planning efforts.				X
5. OMCFH partners with the March of Dimes to provide			X	

education targeting early prenatal care.				
6. OMCFH partners with the local DHHRs to encourage referral of pregnant women who are denied Medicaid coverage for obstetrical care services.		X		
7. RFTS receives a monthly print out sent electronically from Medicaid of those women who were denied Medicaid coverage during pregnancy. RFTS notifies the person by phone and/or letter of OMCFH available services.		X		
8.				
9.				
10.				

b. Current Activities
The RFTS Project continues to use the automated system of sending out invitation letters to all Medicaid eligible pregnant women and infants.

The WV RFTS Project is committed to producing improvements in access to early and adequate prenatal care for low income pregnant women using the home visitation provider network who work and reside in the communities they serve. Providers complete the PRSI when women come to their health care facilities seeking pregnancy testing. When the pregnancy is confirmed, the PRSI is completed and forwarded to the RFTS RCC who immediately refers the client to a DCC to initiate home-based care coordination services.

Right From The Start provides direct financial assistance for obstetrical care for some WV pregnant women who are uninsured or underinsured and are above income guidelines for Medicaid coverage. Pregnant women may qualify for assistance with prenatal care through a program entitled Maternity Services if they are a WV resident, have income between 150%-185% of the FPL, are a pregnant teen age nineteen (19) or under, or are a non-citizen. Under this Title V funded service, through Presumptive Eligibility, women who have no funding source for prenatal care coverage or have not yet been approved for coverage can receive assistance for payment of their first prenatal visit, ultrasound, and routine laboratory procedures if ordered on the first visit.

c. Plan for the Coming Year
West Virginia's Perinatal Program, Right From The Start (RFTS), will continue to provide comprehensive perinatal services to low-income women up to sixty days postpartum and care coordination for Medicaid eligible infants up to age one year. Right From The Start will also provide direct financial assistance for obstetrical care for WV pregnant women who are uninsured or underinsured, are above income guidelines for Medicaid coverage, and meet certain qualification guidelines.

The RFTS Project will continue to provide intensive education for participants promoting the importance of access to early and adequate prenatal care, and will continue to be the statewide network through which the March of Dimes provides education, literature to residents and medical providers.

Eight (8) RFTS RCCs will continue to make site visits to OB providers to encourage completion of the PRSI and promote access to early and adequate prenatal care. RCCs will continue to recruit providers for each of their regions so that women do not have to travel long distances to access prenatal care. The WV Director of Perinatal Programs and RFTS RCCs will continue to provide training and education to local DHHR office staff and other community agencies statewide on Maternity Services coverage and how to make a referral to the Project.

D. State Performance Measures

State Performance Measure 1: *Decrease the percentage of high school students in grades 9-12 who are overweight or obese.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		12	12	12	12
Annual Indicator	14.5	14.0	14.7	14.5	28.6
Numerator	18250	17600	18400	18200	35900
Denominator	125578	125578	125578	125578	125578
Data Source				2007 YRBS	2009 YRBS
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11	11	10	10	

Notes - 2009
2009 YRBS
14.4% overweight and 14.2% obese

Notes - 2008
based upon 2007 YRBS
overweight = at or above the 95th percentile for body mass index, by age and sex

Notes - 2007
2007 YRBS
overweight = at or above the 95th percentile for body mass index, by age and sex

a. Last Year's Accomplishments
Data available on the problem of overweight among West Virginia youth are limited. The latest statistics are from the 2009 Youth Risk Behavior Survey. Overall, 14.4% of West Virginia high school students in grades 9 through 12 were overweight and 14.2% were obese.

According to the National Survey on Children's Health, approximately 67,000 of 184,000 West Virginia children ages 10-17 years (36.4%) are considered overweight or obese using BMI-for-age standards. West Virginia ranks 48th in overall prevalence, surpassed only by Mississippi, Kentucky, and the District of Columbia.

West Virginia children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, but they're also more likely to spend 2 hours or more in front of a television or computer screen.

More than 250 state and local policy-makers and childhood obesity prevention advocates were invited to particpate in the Robert Wood Johnson Foundation's Leadership for Healthy Communities' childhood obesity prevention policy summit that was held May 7-8, 2009 in the nation's capital. In 2003, the WV Medical Foundation received a grant from the Claude Worthington Benedum Foundation to convene a statewide coalition (now named the Partnership for a Healthy WV) comprised of business, education, healthcare, non-rofit and government organizations to develop a collaborative effort to address the problem of obesity in the state. The group provided policy recommendations to Governor Joe Manchin that were incorporated into the WV Healthy Lifestyle Act of 2005. This legislation established an Office of Healthy Lifestyles and a 13 member Coalition chaired by First Lady Gayle Manchin.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. National companies have agreed to remove harmful soft drinks from school machines				X
2. The DHHR Office of Healthy Lifestyles promotes physical activity				X
3. Recent legislation mandates three 30 minute physical activity periods during each week of the school year				X
4. The West Virginia Department of Education is promoting healthy lifestyles				X
5. Cardiac Project provides free school-based BMI, BP, etc. for elementary and middle school students		X		
6. The Kids First Screening Initiative and EPSDT assessments capture BMI				X
7.				
8.				
9.				
10.				

b. Current Activities

The HealthCheck Program has purchased Body Mass Index (BMI) wheels for distribution to primary care providers (medical homes) throughout the state. The documentation of body mass is an invaluable tool for primary care providers (medical homes) to offer appropriate health education and anticipatory guidance.

The WV Bureau for Public Health has partnered with the WV Department of Education's Office of Healthy Schools to address the WV Healthy People 2010 Objectives. Collaborative projects have included collecting data to establish baselines, completing inventories, developing Walk to School initiatives, and training principals.

Coronary Artery Risk Detection in Appalachian Communities (CARDIAC) is facilitated by West Virginia University. This Project is a partnership between local schools and the Rural Health Education Partnership primary care centers. Fifth-grade students are screened for cholesterol, hypertension, and obesity.

Healthy Hearts is a web-based instructional module for children on cardiovascular health. This is one of the first instructional (e-learning) modules that uses the Internet to teach youngsters about the risk factors associated with cardiovascular disease (cholesterol, poor nutrition, physical inactivity, and tobacco use).

c. Plan for the Coming Year

The West Virginia OMCFH indirectly supports early identification of weight problems through the HealthCheck Program, the state's EPSDT Program. Through its protocols, medical practitioners conducting well-child examinations are instructed to measure children for height, weight, and body mass index. HealthCheck will partner with the Office of Healthy Lifestyles to create a medical provider "BMI Tool Kit." The tool kit will contain materials to support the prevention, assessment, and treatment of pediatric obesity issues.

To this end, West Virginia plans to continue to try everything from dance-related video games in schools to increasing the amount of time spent in physical education classes, all aimed at combating a problem that costs state health plans more than $200 million annually.

Medicaid Managed Care organizations are offering counseling for high risk populations for weight control and healthy eating habits.

Camp NEW YOU, offered by the WVU School of Medicine and the School of Physical Education provides opportunities for youth and their parents to practice lifestyle changes that enable them to achieve and maintain a healthy body weight. This residential camp is available on the college campus and targeted to 11-14 year olds.

State Performance Measure 2: *Decrease the percentage of high school students who smoke cigarettes daily.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		19	18.5	18	17.5
Annual Indicator	19.3	19.0	19.5	19.4	9.2
Numerator	24236	23800	24500	24300	11500
Denominator	125578	125578	125578	125578	125578
Data Source				2007 YRBS	2009 YRBS
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	17	16.5	16	16	

Notes - 2009
2009 YRBS

Notes - 2008
Based upon 2007 YRBS

Notes - 2007
2007 YRBS

a. Last Year's Accomplishments
The 2009 YRBS shows that the percentage of students who ever smoked cigarettes daily, that is, at least one cigarette every day for 30 days has decreased slightly to 17.7%, however the 2009 YRBS also shows that smoking within the last 30 days has decreased from 38.5% in 2000 to 21.8% in 2009. The percentage who reported they have never smoked cigarettes rose from 25.7% to 44.8% from 2000 to 2009.

RAZE, the statewide teen-led, teen-implemented anti-tobacco movement, is coordinated by the Youth Empowerment Team (YET). YET members include representives of the Division of Tobacco Prevention, the West Virginia Department of Education's Office of Student Services and Health Promotion, the American Lung Association of West Virginia and the West Virginia Youth Tobacco Prevention Campaign. The goal of RAZE is to create a statewide youth anti-tobacco movement that initiates concern and activism, with peer-to-peer influence ultimately reducing tobacco use among teens. Their vision statement is: "We are RAZE: West Virginia teens, tearing down the lies of Big Tobacco and fighting them with all we've got: our passion, our power and our minds. Join up, if you think you can handle it."

RAZE Crews, groups of teens making a difference, are in over 140 schools and communities in West Virginia.

TAC (Teen Advisory Council) members get a chance to be in charge of a number of important duties for RAZE. TAC members meet once a month either in person or by conference call. TAC plans, organizes and implements a number of various trainings and commotions. They also provide feedback on RAZE issues such as ads, gear, etc.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The WV DHHR and Department of Education have strong anti-tobacco programs which include a brand and promotional campaign designed with advice from youth in this age group.			X	
2. The Adolescent Health Initiative warns of the dangers of tobacco use.		X		
3. RAZE is West Virginia's teen led anti-tobacco movement.			X	
4. Smoking bans in government buildings and state vehicles.				X
5. As of January 2009, all 55 counties have clean indoor air regulations.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Adolescent Health Initiative (AHI) and the Abstinence Education Project (AEP) educate youth about the consequences of tobacco use and encourage responsible behavior. Both programs partner with RAZE and other prevention programs to facilitate community-based activities and events promoting awareness.

West Virginia is aggressively addressing this problem by implementing evidence-based comprehensive tobacco control programs. The comprehensive plan focuses on four goals: (1) Prevent the initiation of tobacco products among young people; (2) Eliminate exposure to secondhand smoke; (3) Promote quitting among adults and young people; (4) Eliminate tobacco-related disparities among different population groups.

c. Plan for the Coming Year

West Virginia's Youth Tobacco Prevention Program's goal is to prevent WV's youth from using tobacco products, even trying them, and to assist the youth who are using tobacco products in reducing the amount they use or quitting. The Youth Program works closely with the WV Department of Education (WVDE) on tobacco related issues including policy and enforcement. The Regional Tobacco Prevention Specialist (RTPS) Network is facilitated and managed through the Office of Healthy Schools, WVDE and the Division of Tobacco Prevention, WVDHHR. The Youth Program also collaborates with the American Lung Association of WV (ALA) to address the community needs of the state and provide facilitation for both schools and communities. The WVDE and the ALA work with the Youth Program and The Arnold Agency to support RAZE. RAZE is West Virginia's teen led anti-tobacco movement. For more information go the RAZE website at www.razewv.com

West Virginia's youth-led tobacco prevention initiative is moving beyond the school system to reach more teens. RAZE is accepting applications for grants to begin new RAZE chapters,

referred to as crews. Up to 200 grants worth $1,000 each will be distributed across the state. Formerly, the program revolved around the education department. Funding was routed through schools, where crews were organized. Now, annual $1,000 grants to form crews are available for community groups and schools alike. There are currently 187 RAZE crews in the state's schools and 200 grants. As the transition is made, they would like to see a shift in RAZE's mission as well. Instead of focusing solely on awareness activities, they hope teens take on policy issues and lobby for clean indoor air legislation and more tobacco restrictions.

State Performance Measure 3: *Decrease the percentage of pregnant women who smoke.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		24	23	22	21
Annual Indicator	32.0	29.0	30.0	28.7	28.2
Numerator	6670	6070	6595	6160	6000
Denominator	20834	20931	22017	21492	21299
Data Source				2008 PRAMS	2008 PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	20	20	20	20	

Notes - 2009
based upon 2008 PRAMS data - mom smoked last 3 months of pregnancy and preliminary 2009 births

Notes - 2008
2008 PRAMS data - mom smoked last 3 months of pregnancy

Notes - 2007
2007 PRAMS data - mom smoked last 3 months of pregnancy

a. Last Year's Accomplishments
West Virginia has among the highest smoking rate for pregnant women in the United States. 2008 data from the WV Health Statistics Center show that the rate of smoking during pregnancy in WV was 27.0% compared to the National rate of 10.7% in 2005 (last available national information). Alarming rates, and of these were 40.7% of the Medicaid insured mothers smoked during pregnancy. 11.7% of the Non-Medicaid insured women in West Virginia reported smoking during pregnancy.

According to the WV Birth Score, among the 45,618 mother's who provided data for 2009, 14,438 (31.6%) reported using tobacco. Of the 5,217 PRSI referrals received by RFTS, 2,447 (47%) were self reported smokers. This creates an enormous health problem for the State of WV which affects not only the developing infant but the pregnant woman, her children, and other exposed family and friends, as well as the health care community. To address this issue, RFTS continued to implement the intense smoking cessation initiative, SCRIPT, developed by Dr. Richard Windsor, MS, PhD, MPH, George Washington University Medical Center, Department of Prevention and Community Health. Educational tools such as videos, Carbon Monoxide Breathalyzers and smoking cessation guides were available for use during home visits. Additional Carbon Monoxide Breathalyzers and supplies along with smoking cessation DVDs,

guides and literature were purchased using WV Division of Tobacco Prevention funding in 2009. A DVD player has been assigned to each DCC to use during home visiting sessions to educate pregnant smokers on the risks of tobacco use, secondhand smoke exposure and smoking cessation.

The RFTS SCRIPT Policy and Management Committee (PMC) met four times during 2009 to ensure regular communication, collaboration and consensus among program leadership. The PMC consists of staff from George Washington University, all eight RFTS Regional Care Coordinators (RCCs), the Directors and two program staff of the Division of Perinatal and Women's Health, Office of Maternal, Child and Family Health, two Designated Care Coordinators (DCCs), two members of the Office of Epidemiology and Health Promotion, one representative of the Birth Score Office, one representative of the WV Tobacco Quitline, one representative of the March of Dimes and one representative of the WV Hospital Association.

The RFTS SCRIPT OB-MD/RN Advisory Committee met once in 2009. This committee is comprised of eight physicians, four registered nurses and one member of the WV Hospital Association. The OB-MD/RN Committee was established to provide advice to the SCRIPT PMC on issues such as: how to improve DCC and OB/MD-RN communication regarding SCRIPT; how to increase delivery of the brief SCRIPT "ASSIST" methods by OB staff; and how to increase the percent of OB staff who advise clients to use the WV Tobacco Quitline.

A DCC Adoption Survey was completed by RFTS DCCs throughout the state. Dissemination of the surveys started in 2008 and concluded in March 2009. GWU disseminated surveys to DCCs to determine their perception of the SCRIPT Program. Approximately 85 DCCs responded to the survey. Results from the surveys will be used to revise the SCRIPT Program to best fit the needs of the DCCs and other healthcare providers.

The SCRIPT Tobacco Use Study started in July 2009. Select DCCs collect saliva samples from clients willing to participate in the study. Saliva samples are obtained at screening and follow-up visits for participating prenatal clients. The study will consist of approximately 100 non-smokers and 200 smokers. The saliva samples will be used to measure cotinine levels. The cotinine levels will provide the Program with an indication of smoking disclosure and non-disclosure rates and it is also an effective way to determine smoking prevalence in the RFTS population.

Two focus groups were completed by GWU with RFTS clients and their family members in June 2009. The primary objectives of these focus groups were to: identify individual and familial factors that influence a woman's decision to smoke, try to quit smoking, and quit; identify client recommendations to revise the "Commit to Quit" DVD, A Pregnant Woman's Guide to Quit Smoking, and other SCRIPT counseling methods and materials.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Smoking Cessation Program (SCRIPT) developed by Dr. Richard Windsor in January 2002 and is ongoing				X
2. The WV SCRIPT uses the existing home visitation network and protocols in the RFTS Project.		X		
3. All pregnant RFTS smokers/former smokers are offered CO Testing and Smoking Cessation.		X		
4. SCRIPT mandated to be offered to all RFTS/HAPI participants.				X
5. Information collected in OMCFH Research Division's Tobacco Screening databases.				X
6. The effects of smoking during pregnancy are distributed			X	

universally.				
7. State government maintains Quit Line.				X
8.				
9.				
10.				

b. Current Activities

Collaborative efforts continue with Dr. Richard Windsor, MS, PhD, MPH, Professor, Department of Prevention and Community Health, School of Public Health and Health Services, George Washington University Medical Center, Washington, D.C., SCRIPT consultant, and WV agencies that have interest in smoking cessation among pregnant women. Dr. Windsor received notification in October 2007 of a grant award from the National Cancer Institute for 2007-2011. The George Washington University Institutional Review Board approved the project and will use West Virginia RFTS as a model of an entire system of care for evidenced based interventions for pregnant Medicaid smokers. One of the primary objectives of the grant is to institutionalize the intervention with staff during/after the grant and evaluation is completed.

The RFTS Project continues to collaborate with the WV Tobacco Quitline. All pregnant women that are smoking are provided information regarding services through the Quitline. Referrals are completed by the DCCs for any RFTS client requesting Quitline services. The Quitline may be used in conjunction with RFTS services if the pregnant woman chooses both interventions.

A virtual training CD, "Smoking Cessation for Pregnancy and Beyond-Learn Proven Strategies to Help Your Patients Quit", continues to be used as part of the training curriculum, for both new and existing DCCs.

c. Plan for the Coming Year

The RFTS Project will continue to collaborate with the WV Tobacco Quitline. The Quitline offers nicotine replacement therapy (NRT) options, free of charge, to pregnant women, with a physician's order. NRT products are also available to family members living in the home of the pregnant woman. RFTS DCCs will continue to provide pregnant RFTS clients with information regarding services available through the Quitline. DCCs will also make referrals for any RFTS client requesting Quitline services.

The RFTS Project will continue to educate pregnant women and their families on the dangers of smoking during pregnancy and the importance of maintaining a smoke free environment as the DCCs continue to make home visits and use the 5 A's best practice method for smoking cessation during pregnancy. The DCCs will continue using a carbon monoxide monitor to provide a visual message of the dangers of smoking during pregnancy.

The RFTS SCRIPT Program will complete the Tobacco Use Study during 2010. The study, consisting of approximately 100 non-smokers and 200 smokers, will provide an indication of smoking disclosure and non-disclosure rates and aid in determining smoking prevalence in the RFTS population.

Utilizing funding provided by the WV Division of Tobacco Prevention, educational tools such as videos, Carbon Monoxide Breathalyzers/accessories, smoking cessation guide and smoking cessation incentives will be purchased for DCCS to use during home visits

State Performance Measure 4: *Increase the percentage of women who breastfeed their infants for at least six (6) weeks after birth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		37	38	57	55
Annual Indicator	22.0	56.0	32.5	32.5	32.7
Numerator	4580	11730	7150	7150	7200
Denominator	20834	20931	22017	22017	22000
Data Source				2007 PRAMS	2007 PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55	55	55	55	

Notes - 2009
based upon 2007 PRAMS data - mom breastfeeding at 8 weeks

Notes - 2008
2007 PRAMS data - mom breastfeeding at 8 weeks

Notes - 2007
2007 PRAMS data - mom breastfeeding at 8 weeks

a. Last Year's Accomplishments
While the latest data on breastfeeding indicate that a low percentage of women choose to breastfeed their infants, this should not be taken as an indication of little effort on the part of the State's Bureau for Public Health or, in particular, the Office of Maternal, Child and Family Health (OMCFH). All pregnant women participating in the Right From The Start Project (RFTS) receive information about the benefits of breastfeeding their infants. RFTS Project DCCs provide comprehensive in-home breastfeeding education and support to prenatal participants through sixty days post partum and to breastfeeding mothers of eligible infants until their infant reaches age one year.

After learning of ineffective community collaboration between RFTS and West Virginia WIC providers, the Director of Perinatal Programs voiced concerns regarding this matter to the Director of the Office of Nutrition Services. RFTS DCCs report that collaborative efforts have improved. This improvement provided RFTS participants with better continuity of care and resulted in an increase in the number of pregnant women referred to RFTS for care coordination. This in turn provided an opportunity for more breastfeeding education and support and is evidenced by the steady increase in breastfeeding rates of RFTS Project participants reported above.

In 2009, The RFTS Project continued to be involved in a collaborative strategic planning effort to develop a cross-referral system for service integration and coordination. It was decided that the most logical system to use statewide would be Systems Point of Entry which is housed within OMCFH.

Educational tools such as videos, DVDs, brochures, The Pregnancy Workshop and medical models were available to RFTS DCCs for use on home visits to promote breastfeeding.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increased WIC resources, money, and personnel dedicated to				X

breastfeeding.				
2. WIC goals include providing additional funds to local agencies that will allow breastfeeding peer counselors to visit local hospitals and physicians practices in order to keep mothers breastfeeding longer.				X
3. Increased attention by multiple service agencies serving pregnant women including physicians, RFTS, etc. needed to encourage and offer breastfeeding support.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Project participants are encouraged to breastfeed and educated on health and socioeconomic benefits to mother and infant. The social and economic benefits of breastfeeding are emphasized to show families that they can potentially save money when comparing the cost of breastfeeding to the cost of using formula. Breastfeeding is convenient and safer because breast milk is always available at the correct temperature, is sterile, and requires no mixing.

The RFTS Project continues to encourage collaboration with local WIC offices statewide to ensure that participants receive breastfeeding education and support after case closure.

c. Plan for the Coming Year

The RFTS Project will continue to provide educational materials on breastfeeding such as videos, pamphlets, and literature for DCCs to use during home visits. RFTS DCCs promote breastfeeding with each prenatal participant and provide support and referrals as needed. RFTS will continue to train DCCs on the benefits of breastfeeding and how to encourage participants to try breastfeeding as their choice for infant feeding.

RFTS is committed to increasing breastfeeding rates throughout WV and promoting optimal breastfeeding practices. This goal can be achieved through the existing RFTS Project network by supporting breastfeeding mothers, their families, communities, employers, and health care providers by providing education, training, funding, technical assistance, and research.

State Performance Measure 5: *Decrease the percentage of high school students who drink alcohol and drive.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		10	10	9.5	9
Annual Indicator	10.6	10.4	10.0	9.8	7.5
Numerator	13300	13000	12500	12300	9400
Denominator	125578	125578	125578	125578	125578
Data Source				2007 YRBS	2009 YRBS

Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8.5	8	8	8	

Notes - 2009
2009 YRBS

Notes - 2008
Based upon 2007 YRBS

Notes - 2007
2007 YRBS

a. Last Year's Accomplishments
The West Virginia Abstinence Education Project (AEP), in partnership with the COFY Coalition developed Drug-Free All-Stars, a basketball team comprised of community prevention partners, law enforcement and local business leaders in Wyoming, Mercer and McDowell Counties. The team plays students and teachers at local schools while promoting healthy lifestyle choices.

The Director for the Adolescent Health Initiative partnered with the Kanawha County Communities That Care partnership and the Kanawha County Sheriff's office to obtain a $21,200 grant to combat underage drinking. The funds were used to pay for "alcohol sting" activities such as; DUI checkpoints, sending kids into stores to try to buy alcohol, shoulder tap activities, and utilizing undercover police officers to pose as employees in businesses that sell alcohol.

The Region VII AHI Coordinator conducted workshops on alcohol prevention at Doddridge County High School Teen Issues Day.

The AEP, in partnership with other prevention programs and community leaders, sponsored Drug Free Alternative Day in McDowell County. Parents and youth received prevention information on alcohol, tobacco and other drugs.

The AEP sponsored an alcohol-free "After Prom Party" in Ritchie County, WV.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Students Against Destructive Decisions (SADD) works with communities to establish local chapters.		X		
2. Adolescent Health Initiative promotes healthy decision making.			X	
3. State alcohol distribution policy protects youth.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Adolescent Health Initiative (AHI) partners with SPF-SIG implementation grant recipients across the state to develop substance abuse prevention plans for nineteen of West Virginia's fifty-

five counties.

The AHI Coordinators participate in substance abuse coalitions across the state including, but not limited to, Upshur, Doddridge, Monongalia, Lewis, Brooke, Hancock, Ohio, Marshall, Greenbrier, Fayette and Summers Counties. These coalitions are comprised of school counselors, law enforcement, school-based health professionals, mental health professionals, parents, youth and other community and business partnerships.

The AHI disseminates literature and educational material to communities across West Virginia educating students about the dangers of sexual activity, alcohol and drug use.

c. Plan for the Coming Year
The Adolescent Health Initiative will create public awareness, promote, and educate people about the power of the asset development approach as it relates to reducing underage drinking and other risk behaviors.

The Adolescent Health Initiative will collaborate with other regional network partners, educate youth and parents, and provide informational literature about unintentional injury, drinking and driving, use of seatbelts and other risk behaviors.

The Adolescent Health Initiative will facilitate at least eight trainings across the state (one per region) designed to encourage youth to make positive choices and avoid risky behaviors such as drinking and driving. Trainings will target adolescents, parents and/or other community members.

State Performance Measure 6: *Decrease the number of high school students who never or rarely wear a seatbelt when riding in a car driven by someone else.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		15	14.5	14	13.5
Annual Indicator	15.2	15.0	16.6	16.4	14.0
Numerator	19087	18800	20800	20600	17600
Denominator	125578	125578	125578	125578	125578
Data Source				2007 YRBS	2009 YRBS
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	13	12.5	12	12	

Notes - 2009
2009 YRBS
never 5.4% and rarely 8.6%

Notes - 2008
Based upon 2007 YRBS - only conducted ever other year

Notes - 2007
2007 YRBS

a. Last Year's Accomplishments

The Adolescent Health Initiative participated in several health and safety events across West Virginia and distributed information regarding seatbelt usage to adolescents, parents and other community members. The Adolescent Health Initiative Director collaborated with the Governor's Highway Safety program to launch a statewide campaign that included billboards and electronic seatbelt usage signs. The Adolescent Health Initiative Director also worked with Kanawha Coalition for Health Improvement and the Charleston Police Department to sponsor seatbelt and child safety seat checkpoints throughout the City of Charleston.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WV Department of Transportation promotes seat belt use.				X
2. WV Department of Public Safety sponsors the "Click It or Ticket" campaign and has put an emphasis on enforcement of seat belt usage laws.				X
3. WV state law requires seat belt use.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Adolescent Health Initiative collaborates with other regional network partners to provide a minimum of 64 (8 per region) presentations to educate youth and parents, and distribute informational literature about unintentional injury, drinking and driving, use of seatbelts.

The Adolescent Health Initiative encourages parents and youth to seek access to needed health care services to include health screenings, dental exams and adolescent immunizations and make referrals as needed.

c. Plan for the Coming Year

The Adolescent Health Initiative will work with community partners, schools, and local law enforcement to encourage seatbelt usage among adolescents. Regional Adolescent Health Coordinators will be required to conduct presentations and disseminate information throughout their regions about the importance of wearing seatbelts, the dangers of "distracted" driving (i.e. texting, multiple passengers) and other known risk factors for adolescent vehicular injury and death.

State Performance Measure 7: *Increase the percentage of the state's children <18 who are government sponsored beneficiaries who have at least one primary care visit in a 12-month period.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		90	90	90	92
Annual Indicator	88.2	88.7	89.6	81.4	86.2

Numerator	200354	232500	233427	158651	173286
Denominator	227222	262222	260614	194998	201013
Data Source				CMS-416 Fiscal Year 2008 Annual Report	CMS 416 Fiscal Year 2009
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	92	92	93	93	

Notes - 2009
CMS-416 Fiscal Year 2009 Annual Report

Notes - 2008
CMS-416 Fiscal Year 2008 Annual Report

a. Last Year's Accomplishments
EPSDT/HealthCheck utilization remains at 50%. EPSDT Family Outreach Workers inform parents and care-takers of Medicaid eligible children not enrolled in Medicaid Managed Care about EPSDT services locating a medical home and encourage them to use the EPSDT services for preventive health. A Program Specialist employed by OMCFH is assigned to each region and provides orientation of new EPSDT providers, technical assistance, orientation of new staff members, an annual review of all EPSDT program requirements, and a minimum of two site visits each fiscal year for all existing EPSDT providers.

The OMCFH HealthCheck staff only does outreach for EPSDT members not assigned to an HMO. Six counties are covered by one HMO and PAAS. The remaining forty-nine counties are covered 100% by HMOs, although seven of these forty-nine counties do not afford beneficiaries a choice between at least two managed care plans.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote routine health care utilization via Healthy Schools			X	
2. Promote the Governor's Kid First Initiative to screen school enterers using HealthCheck protocols			X	X
3. 100% of children in program receive notification about needed screens		X		
4. Participate in development of public informing materials				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
WVCHIP continues to partner with several state agencies and community health programs as a way to refocus WVCHIP's outreach efforts as a leader in health prevention and promoting a healthy lifestyle. Collaborations are important to allow multiple agencies and entities inside and outside state government to integrate efforts related to a statewide mission for the health of West Virginia's children. WVCHIP has embarked on several health intervention and prevention initiatives that have involved the Infant, Child, and Adolescent Health Division within OMCFH as

well as other Offices within the Bureau for Public Health.

Currently, WVCHIP is focusing on educating families on the importance of well-child visits, immunizations, reducing unnecessary emergency room visits, child development and asthma and diabetes case-management.

Several groups and coalitions have asked Medicaid to revise its newly redesigned Medicaid plan. They contend that the redesign will not get the intended results.

The Kids First Screening Initiative was launched last year with the support of WV Govenor, Joe Manchin. Kids First's HealthCheck is a comprehensive screening that includes hearing, speech, language, and growth and development. Beginning the school year 2008-09, all children enrolling in kindergarten received this exam.

c. Plan for the Coming Year
The EPSDT Program will continue to be operated by the OMCFH through a contractual arrangement with the Bureau for Medical Services and renegotiated every year. EPSDT providers plan to continue offering EPSDT services in the School Based Health Centers as a way to be more accessible for those children who may not otherwise receive services due to restricted access.

EPSDT has been successful in increasing the overall number of EPSDT providers over the past several years and routinely provides orientation for HMO providers serving Medicaid enrolled children. These activities have been helpful in establishing the desired eligible child to provider ratio; however, the influx of CHIP eligibles has presented an additional challenge since the WV medical community often lacks capacity in some areas of the state.

The health care reform bill is the expansion of the Children's Health Insurance Program to include families with incomes up to 300% FPL. Over the next few years an additional 4,000 plus West Virginia children will receive health insurance through this expansion. The CHIP expansion is projected to achieve a 97% rate of children who have health insurance.

WVCHIP will continue partnerships with several state agencies and community health programs and focus on healthy lifestyles and prevention efforts.

State Performance Measure 8: *Increase the percentage of high school students who participate in physical activity for at least 20 minutes a day, 3 days a week.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		68	69	50	50
Annual Indicator	63.7	65.0	42.8	43.0	41.8
Numerator	79993	81600	53700	54000	52500
Denominator	125578	125578	125578	125578	125578
Data Source				2007 YRBS	2009 YRBS
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55	55	60	60	

Notes - 2009
2009 YRBS

Notes - 2008
Based upon 2007 YRBS - question is actually stated as percentage of students who were physically active for a total of at least 60 minutes per day on five or more of the past seven days.

Notes - 2007
2007 YRBS - question is actually stated as percentage of students who were physically active for a total of at least 60 minutes per day on five or more of the past seven days.

a. Last Year's Accomplishments
According to the 2007 National Survey of Children's Health, Indicator 1.5: "During the past week, on how many days did [child name] exercise, play a sport, or participate in physical activity for at least 20 minutes that made [him/her] sweat and breathe hard?" reports that 10.0% of WV children age 12-17 exercised/did physical activity 0 days in the past week, 28.4% exercised/did physical activity for 1-3 days in the past week, 35.4% exercised/did physical activity 4-6 days in the past week, and 26.3% exercised/did physical activity everyday in the past week.

NSCH numbers differ so greatly from the 2009 YRBS because the YRBS question is actually stated "During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day." 17.3% were never active, 9.5% were active for 1 day, 11.1% were active for 2 days, 11.0% were active on 3 days, 9.4% were active on 4 days, 10.8% were active on 5 days, 8.4% were active on 6 days, and 22.6% were active on all 7 days.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The WV DHHR Office of Healthy Lifestyles promotes physical activity				X
2. Recent legislation requires three periods of physical activity each week (30 minutes in length) during the school year for grade school				X
3. Recent legislation requires one semester each year for middle school				X
4. Recent legislation requires one class of physical education during high school				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Physical education can be a vehicle through which high school students transition from adolescence to adulthood. High school physical education programs should focus on fitness, offer diverse movement patterns, development of motor skills and emphasize lifetime activities. Students need to be exposed to a wide variety of activities, both competitive and noncompetitive that bring them enjoyment and challenge, thus enabling them to maintain an active lifestyle for a lifetime. The West Virginia Standards for 21st Century Learning include the following components: 21st Century Content Standards and Objectives and 21st Century Learning Skills and
Technology Tools. All West Virginia teachers are responsible for classroom instruction that integrates learning skills, technology and objectives.

In accordance with W. Va. Code Section 1827a, the FITNESSGRAM(r) shall be administered to all students.

c. Plan for the Coming Year

The WV Board of Education believes that county boards of education can make a positive impact on promoting healthy lifestyles among students and staff through the development and implementation of proactive local wellness policies. In addition, the Board believes all schools should provide a consistent environment that is conducive to healthful eating behaviors and regular physical activity. The WVBE set forth expectations and encouraged county boards to prepare, adopt and implement a comprehensive nutrition and physical activity plan that included specific standards.

E. Health Status Indicators

Introduction

Improvement in the health of West Virginia's perinatal population is a result of a carefully crafted, highly-interdependent partnership. Tertiary care centers, primary care centers, local health departments, private practitioners and community agencies have worked with the Office of Maternal, Child and Family Health (OMCFH) for nearly 30 years to improve the health and well-being of the State's people. In conjunction with its medical advisory boards, OMCFH has designed a system that offers early and accessible health care to low income, medically indigent and underinsured women and children. A successful system requires adequately trained professionals to provide complete reproductive health services that include family planning, preconceptual counseling, prenatal care, delivery, newborn care, and care for the woman in the postpartum period.

OMCFH has a commitment of ensuring healthy births, reducing the incidence of low birth weight, and improving the health status of West Virginia's children. OMCFH also recognizes the importance of maximizing scarce fiscal resources and the benefit of collaborative efforts in the development of programs that support shared goals. West Virginia's efforts to improve the health status of pregnant women and children have been successful over time as evidenced by broadened medical coverage, streamlined medical eligibility processes, shared government funding, targeted outreach, risk reduction education, and development of comprehensive programs.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.5	9.7	9.5	9.5	9.4
Numerator	1984	2020	2102	2050	2000
Denominator	20834	20931	22017	21492	21299
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
based upon 2008 Vital Statistics and preliminary 2009 births

Notes - 2008
2008 Vital Statistics

Notes - 2007
2007 Vital Statistics

Narrative:
West Virginia has struggled with the incidence of low birth weight infants. Birth weight is the single most important predictor of survival. Low birth weight is defined as a weight of less than 2,500 grams at birth and may result from preterm birth (before 37 weeks) or poor fetal growth for a given duration of pregnancy (intrauterine growth retardation) or both. Risk factors for preterm birth and low birth weight include: previous preterm and/or low birth weight birth, multiple births, smoking, unplanned pregnancy, infections, poor nutrition, lack of access to adequate and early prenatal care, harmful substance abuse, and domestic violence.

There was a total of 2,050 low birth weight babies (those weighing less than 2,500 grams or 51/2 pounds) born to West Virginia residents in 2008, 9.5% of all births. Of the 2,050 low birth weight infants, 1,354 or 66.0% were preterm babies born before 37 weeks of gestation. (Of all 2008 resident births with a known gestational age, 11.8% were preterm babies.) Of the births with known birth weight, 9.4% of babies born to white mothers and 14.5% of babies born to black mothers were low birth weight. Nationally, 8.2% of all infants weighed less than 2,500 grams at birth in 2008; 7.2% of white infants and 13.8% of black infants were of low birth weight.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.4	9.1	7.8	8.0	7.9
Numerator	1537	1912	1725	1670	1650
Denominator	20834	20931	22017	20826	20900
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
based upon 2008 Vital Statistics

Notes - 2008
2008 Vital Statistics

Notes - 2007
2007 Vital Statistics

Narrative:
While it is desired for all newborns to be born at a healthy weight, some factors are hard to influence. In regard to too little and too soon newborns, it is intended to use maternal risk screening as a means of assuring predicted high birth babies are birthed at hospitals appropriate to meet need. Prevention efforts have been repeatedly discussed throughout this application.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.6	1.5	1.6	1.4	1.3
Numerator	339	304	359	305	280
Denominator	20834	20931	22017	21492	21299
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
based upon 2008 Vital Statistics and preliminary 2009 births

Notes - 2008
2008 Vital Statistics

Notes - 2007
2007 Vital Statistics

Narrative:
In 2008, 305 infants were born weighing less than 1,500 grams. Over one-fourth (27.0%) of the 21,492 births in 2008 were to mothers who smoked during their pregnancies, while 0.3% of births were to women who used alcohol. National figures from 2005 show that 10.7% of women giving birth reported smoking during pregnancy; 0.8% used alcohol in 2004 (the latest data available). Among the state mothers who reported smoking during pregnancy, 14.0% of the babies born were low birth weight, compared with 7.9% among non-smoking mothers. Over one-third (35.7%) of 2008 state births were delivered by Cesarean section, compared with a 2007 national rate of 31.8%. One or more complications of labor and/or delivery were reported for 32.2% of deliveries in the state in 2008.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.2	1.1	1.2	1.2	1.1
Numerator	245	239	255	248	225
Denominator	20834	20931	22017	20826	20900
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
based upon 2008 Vital Statistics

Notes - 2008
2008 Vital Statistics

Notes - 2007
2007 Vital Statistics

Narrative:
The percent of WV live singleton births weighing less than 1,500 grams was 1.2% for 2008. HB 2837, the Uniform Maternal Screening Act, passed during the 2009 WV legislative session, establishes an advisory council within the WV DHHR, Office of Maternal, Child and Family Health to assist in developing a uniform maternal risk screening tool. Once developed, all health care providers offering maternity services will be required to utilize the tool in their examinations of any pregnant woman, maintain confidentiality and notify the woman of any high-risk condition which they identify along with any necessary referral.

A uniform approach will simplify the process, standardize procedures and identify pregnancies that need more in-depth care and monitoring. Additionally, a uniform application will provide measurable data regarding at-risk and high-risk pregnancies. This will allow public health officials to analyze conditions that are most frequently observed and to develop methodology to address concerns.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.0	8.2	9.5	9.8	9.5
Numerator	23	27	30	31	30
Denominator	329137	329137	316809	316986	317000
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
based upon 2008 Vital Statistics

Notes - 2008
2008 Vital Statistics

Notes - 2007
2007 Vital Statistics

Narrative:
The West Virginia Injury Prevention and Control Program provides coordination of injury prevention activities throughout West Virginia by building partnerships with other state and local organizations.

As the state's land-grant flagship institution for both research and patient care, West Virginia University (WVU) is committed to improving the health and safety of West Virginians, and contributing to the national effort to reduce injuries. While significant improvements in emergency medicine, trauma and injury prevention have occurred over the last 15 years, there remains a critical need for injury research, professional training, and information dissemination activities throughout the state and surrounding region. The WVU Injury Control Research Center is dedicated to addressing this continuing public health problem.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	3.6	4.6	5.4	3.5	3.2
Numerator	12	15	17	11	10
Denominator	329137	329137	316809	316986	317000
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
based upon 2008 Vital Statistics

Notes - 2008
2008 Vital Statistics

Notes - 2007
2007 Vital Statistics

Narrative:
In 2000, West Virginia had the lowest seat belt usage rate in the country at 49%. The rate went to 52% in November 2001. As a direct result of the Click It or Ticket Program, with the assistance of our law enforcement partners, and a large paid media effort, West Virginia's seat belt usage rate soared to an all time high of 72% in June 2002. In June of 2003, after another sucessful year of the Click It or Ticket campaign, the usage rate jumped to 74%. In June of 2004, the seat belt usage rose another two percentage points to 76% and in June 2005, a scientific seat belt survey was conducted in West Virginia and the results were 85% were wearing their seat belt. The percentage of seat belt usage rose to 88.5% in 2006 and to 89.5% in 2007 and 2008 but has descreased slightly to 87.5% for 2009.

Beginning July 10, 2009, because of legislation passed in the 2009 session, young drivers must follow stronger restrictions on nighttime driving, cell phone use and how many passengers they can carry. Intermediate drivers ages 16 and 17 cannot drive after 10 p.m., not allowed to carry unrelated passengers under age 20 for the first six months and only allowed to carry one for the second six months and not allowed to use cell phones while driving.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	37.0	39.9	36.1	34.3	33.0
Numerator	91	98	83	78	75
Denominator	245687	245687	229772	227161	227250
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
based upon 2008 Vital Statistics

Notes - 2008
2008 Vital Statistics

Notes - 2007
2007 Vital Statistics

Narrative:
In 2008, of the 219 adolescents who died in this age group, 78 were due to motor vehicle accidents.

In 2000, West Virginia had the lowest seat belt usage rate in the country at 49%. The rate went to 52% in November 2001. As a direct result of the Click It or Ticket Program, with the assistance of our law enforcement partners, and a large paid media effort, West Virginia's seat belt usage rate soared to an all time high of 72% in June 2002. In June of 2003, after another sucessful year of the Click It or Ticket campaign, the usage rate jumped to 74%. In June of 2004, the seat belt usage rose another two percentage points to 76% and in June 2005, a scientific seat belt survey was conducted in West Virginia and the results were 85% were wearing their seat belt. The percentage of seat belt usage rose to 88.5% in 2006 and to 89.5% in 2007 and 2008 but has descreased slightly to 87.5% for 2009.

Beginning July 10, 2009, because of legislation passed in the 2009 session, young drivers must follow stronger restrictions on nighttime driving, cell phone use and how many passengers they can carry. Intermediate drivers ages 16 and 17 cannot drive after 10 p.m., not allowed to carry unrelated passengers under age 20 for the first six months and only allowed to carry one for the second six months and not allowed to use cell phones while driving.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	324.2	190.2	256.1	278.0	273.4
Numerator	1067	626	843	915	900
Denominator	329137	329137	329137	329137	329137
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
based upon 2008 Hospital Discharge data, HCA

Notes - 2008
2008 Hospital Discharge data, HCA

Notes - 2007
2007 Hospital Discharge data, HCA

Narrative:
The West Virginia Injury Prevention and Control Program provides coordination of injury prevention activities throughout West Virginia by building partnerships with other state and local organizations.

As the state's land-grant flagship institution for both research and patient care, West Virginia University (WVU) is committed to improving the health and safety of West Virginians, and contributing to the national effort to reduce injuries. While significant improvements in emergency medicine, trauma and injury prevention have occurred over the last 15 years, there remains a critical need for injury research, professional training, and information dissemination activities throughout the state and surrounding region. The WVU Injury Control Research Center is dedicated to addressing this continuing public health problem.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	44.4	23.4	35.9	40.4	38.0
Numerator	146	77	118	133	125
Denominator	329137	329137	329137	329137	329137
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
based upon 2008 Hospital Discharge Data - HCA

Notes - 2008
2008 Hospital Discharge Data - HCA

Notes - 2007
2007 Hospital Discharge Data - HCA

Narrative:
The Governor's Highway Safety Program maintains child safety-seat loaner programs throughout the state. These programs not only give away child safety seats, but also check seats for proper installation and provide education to the parents on the need for a properly installed safety seat. This same Program also operates the ATV Safety Program, which seeks to educate the public on ATV Safety and provides an ATV Safety Class throughout the state.

The Charleston Police Department Community Services Division and the Kanawha County Communities that Care have Safety City, McGruff Messages, Click it or Ticket Messages, DUI checkpoints to make sure kids are buckled and assure the car seats are installed properly. In addition to McGruff, Buckle Bear attends events to encourage children to buckle up. Information and promotion items from the National Highway Safety Administration are given out.

In Charleston, Neighborhood Assistance Officers respond to car accidents and give children involved beanie baby bears to hold and take with them. The paramedics use them to show children what is going to happen when they get to the hospital. Then they can ask the child questions about their bear to try to keep their minds active and off the pain until they transport to the hospital.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	74.8	52.4	80.5	81.1	79.9
Numerator	515	361	554	558	550
Denominator	688401	688401	688401	688401	688401
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
based upon 2008 Hospital Discharge Data - HCA

Notes - 2008

2008 Hospital Discharge Data - HCA

Notes - 2007
2007 Hospital Discharge Data - HCA

Narrative:
In 2000, West Virginia had the lowest seat belt usage rate in the country at 49%. The rate went to 52% in November 2001. As a direct result of the Click It or Ticket Program, with the assistance of our law enforcement partners, and a large paid media effort, West Virginia's seat belt usage rate soared to an all time high of 72% in June 2002. In June of 2003, after another sucessful year of the Click It or Ticket campaign, the usage rate jumped to 74%. In June of 2004, the seat belt usage rose another two percentage points to 76% and in June 2005, a scientific seat belt survey was conducted in West Virginia and the results were 85% were wearing their seat belt. The percentage of seat belt usage rose to 88.5% in 2006 and to 89.5% in 2007 and 2008 but has descreased slightly to 87.5% for 2009.

Beginning July 10, 2009, because of legislation passed in the 2009 session, young drivers must follow stronger restrictions on nighttime driving, cell phone use and how many passengers they can carry. Intermediate drivers ages 16 and 17 cannot drive after 10 p.m., not allowed to carry unrelated passengers under age 20 for the first six months and only allowed to carry one for the second six months and not allowed to use cell phones while driving.

West Virginia continues to develop traffic safety materials targeted at young people. Through collaboration, the Department of Education's school-based health education is being improved to incorporate information on health-related decision making.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	14.3	13.7	15.2	15.3	15.2
Numerator	872	834	928	935	930
Denominator	61043	61043	61043	61043	61043
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
based upon 2008 STD Surveillance Summary Report - DSDC

Notes - 2008
2008 STD Surveillance Summary Report - DSDC

Notes - 2007
2007 STD Surveillance Summary Report - DSDC

Narrative:
WV's education policies require that public schools teach some form of sex education, as it relates to HIV/AIDS prevention. Abstinence-based education is primarily stressed and contraception may be covered as part of basic sexual education. However there is no mandate for sexual education. According to the West Virginia Board of Education's Health Content Standards and Objectives for West Virginia Schools (Policy 2520.5), effective November 12, 2005, "a major focus has been given to what the Center for Disease Control recognizes as adolescent risk behaviors," including "sexual behaviors that result in HIV infection/other STDs and unintended pregnancy." Starting in the seventh grade, students should be able to "analyze the difference between safe and risky behaviors, including methods for preventing pregnancy and STDs (e.g.,abstinence and methods of birth control)."

A state program with a broader approach to sexuality education is the WV Department of Health and Human Resources' Adolescent Pregnancy Prevention Initiative. This program includes abstinence and family planning education and is driven by a group of youth advocates including religious leaders, social workers, teachers and school nurses.

Family planning (FP) continues to offer basic STD counseling, education, screening, diagnosis, and treatment activities. The FP Program, WV Sexually Transmitted Disease Program and WV Office of Laboratory Services jointly administer a pilot project, Urine Based Chlamydia Screening for Women. The pilot project targets women under the age of 25 requesting a urine pregnancy test. Ten FP Program sites were selected to participate based upon clinic volume of urine pregnancy testing. A goal of screening 1,800 women has been set. Once the pilot project and analysis is completed, the findings will be forwarded to each participating agency. Data will be used to determine continued feasibility.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	4.6	4.4	5.0	5.0	5.0
Numerator	1353	1310	1467	1481	1470
Denominator	294987	294987	294987	294987	294987
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
based upon 2008 STD Surveillance Summary Report - DSDC

Notes - 2008
2008 STD Surveillance Summary Report - DSDC

Notes - 2007
2007 STD Surveillance Summary Report - DSDC

Narrative:

Family planning clinics help women plan and space their pregnancies and avoid mistimed, unwanted or unintended pregnancies, reduce the number of abortions, lower rates of sexually transmitted diseases, and significantly improve the health of women, children and families. The WV Department of Health and Human Resources Family Planning Program, housed within OMCFH, despite limited funding, has been ranked sixth nationally in service availability. Services are available confidentially at low or no cost at 153 clinics throughout the state. Any female or male capable of becoming or causing pregnancy whose income is at or below 250% FPL is eligible to receive services. No one is denied services because of inability to pay.

A combination of funds from the U.S. Department of Health and Human Services, Office of Population Affairs, Title V and WV state budget appropriations support most of the services, which include: pregnancy testing; fertility awareness information; free contraceptive methods and supplies; breast, cervical and testicular cancer screenings; and surgical sterilizations for women and men.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	21092	19291	1016	43	158	5	579	0
Children 1 through 4	84343	77138	4061	172	633	22	2317	0
Children 5 through 9	105050	96025	5380	239	740	33	2633	0
Children 10 through 14	106501	98510	5004	217	730	26	2014	0
Children 15 through 19	116745	108528	5667	256	687	41	1566	0
Children 20 through 24	110416	102465	5392	238	1176	50	1095	0
Children 0 through 24	544147	501957	26520	1165	4124	177	10204	0

Notes - 2011

Narrative:
West Virginia is characterized by an aging population and is predominantly white. The largest minority group is African American, with a growing Latino population, especially in the eastern panhandle, located close to Washington, D.C. Of West Virginia's 1.8 million people, 546,581 are ages 0-24. The majority are white, with 40,969 or 7.5% being of another or mixed race.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**

HISPANIC ETHNICITY			
Infants 0 to 1	20684	409	0
Children 1 through 4	82709	1633	0
Children 5 through 9	102968	2082	0
Children 10 through 14	104637	1864	0
Children 15 through 19	115110	1635	0
Children 20 through 24	108932	1484	0
Children 0 through 24	535040	9107	0

Notes - 2011

Narrative:
West Virginia is characterized by an aging population and is predominantly white. The largest minority group is African American, with a growing Latino population, especially in the eastern panhandle, located close to Washington, D.C. Of West Virginia's 1.8 million people, 544,147 are ages 0-24. The majority are white, with 7.8% being of another or mixed race.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	26	24	2	0	0	0	0	0
Women 15 through 17	779	722	46	2	0	1	7	1
Women 18 through 19	1976	1880	81	3	0	1	11	0
Women 20 through 34	16742	15940	609	13	55	82	31	12
Women 35 or older	1969	1846	73	3	16	25	1	5
Women of all ages	21492	20412	811	21	71	109	50	18

Notes - 2011

Narrative:
In 2008 of the 21,492 resident births, 20,412 or 94.9% were to white women, 811 or 3.7% were to Black women and 1.4% were to other races. Of the 811 Black births 129 were to women ages 14-19. Of the 20,412 white births, 2,626 were to women ages 14-19.

Statistics show an increased incidence of poor perinatal outcomes among minority women, and certain perinatal risk factors appear to be more prevalent among this population. Prenatal care is important in evaluating risk, promoting health, and managing complications in pregnancy, yet disparity of and access to care place these vulnerable women at increased risk. The Perinatal Partnership will study these disparities and work to find a solution that works for West Virginia.

Family planning clinics help women plan and space their pregnancies and avoid mistimed,

unwanted or unintended pregnancies, reduce the number of abortions, lower rates of sexually transmitted diseases, and significantly improve the health of women, children and families. In 2009, 883 male teens and 14,734 female teens were served in Family Planning clinics around the state.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	25	1	0
Women 15 through 17	768	11	0
Women 18 through 19	1955	21	0
Women 20 through 34	16544	198	0
Women 35 or older	1929	40	0
Women of all ages	21221	271	0

Notes - 2011

Narrative:
Of the 21,492 resident births in 2008, only 271 were born to mothers of Latino or Hispanic origin. Of those 271 Latino or Hispanic births, 32 were born to Latino teens ages 15-19.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	166	149	17	0	0	0	0	0
Children 1 through 4	37	36	1	0	0	0	0	0
Children 5 through 9	13	9	4	0	0	0	0	0
Children 10 through 14	20	20	0	0	0	0	0	0
Children 15 through 19	80	75	5	0	0	0	0	0
Children 20 through 24	139	133	6	0	0	0	0	0
Children 0 through 24	455	422	33	0	0	0	0	0

Notes - 2011

Narrative:
West Virginia is primarily a homogenous society, with less than 4% black in the total population. Of the 455 deaths for the above age groups 33 or 7% were Black. Of the 33 black deaths, ages 0-24, 17 or 51% were infants. The black infant deaths were characterized by extreme prematurity, born before 27 weeks gestation, unmarried parents, young parents age 21 years or younger and poor adequacy of prenatal visits. Of the 422 white deaths, ages 0-24, 149 or 35% were infants.

The state's 2008 white infant mortality rate increased slightly, from 6.9 in 2007 to 7.3, while the rate for black infants decreased slightly from 22.0 to 21.0.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	165	1	0
Children 1 through 4	37	0	0
Children 5 through 9	13	0	0
Children 10 through 14	20	0	0
Children 15 through 19	79	1	0
Children 20 through 24	139	0	0
Children 0 through 24	453	2	0

Notes - 2011

Narrative:
There were 453 deaths within the population of 0-24 years of age. Deaths of infants and children ages 20-24 were the two largest age groups and combined was 67.1% of deaths for children ages 0-24. Of the 453 deaths, two deaths were reportedly of Hispanic/Latino origin.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	433730	399491	21128	927	2948	127	9109	0	2008
Percent in household headed by single parent	13.3	12.6	35.8	14.8	5.3	20.5	18.4	24.6	2008
Percent in TANF (Grant)	4.4	4.4	0.0	0.0	0.0	0.0	0.0	0.0	2009

families									
Number enrolled in Medicaid	169387	160410	6437	169	338	0	2033	0	2009
Number enrolled in SCHIP	37874	35849	1432	19	84	7	444	39	2009
Number living in foster home care	6476	5306	687	13	19	21	419	11	2009
Number enrolled in food stamp program	116866	116866	0	0	0	0	0	0	2009
Number enrolled in WIC	46344	41239	1854	137	105	21	2988	0	2009
Rate (per 100,000) of juvenile crime arrests	2301.0	2049.0	7309.0	877.0	1010.0	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	2.8	2.8	0.0	0.0	0.0	0.0	0.0	0.0	2009

Notes - 2011
2008 Vital Statistics

2000 Census - male, female head of household with children under 18 divided by total family households

Not broken down by race

Number enrolled on June 30, 2009
Only includes children through age 18
Race calculations based upon CHIP percentages

2009 Annual Report - only includes children through age 18

not broken down by race

Criminal Justice Statistical Analysis Center
Denominator = total children 10-19
Asian and Pacific Islander calculated as one under Asian (reported as one from Statistical Analysis Center)
Total unknown race arrests were 94 - not calculated as rate because unknown total from Vital Statistics was 0

Not broken down by race

AFCARS report

Narrative:

Three of the categories listed above are not broken down by race and indicated in the note sections of each of these data fields. Nearly 48% of West Virginia's children ages 0-19 have been enrolled in either Medicaid or SCHIP in 2008/2009. Of importance to note in the above data is the rate of black juvenile crime arrests compared to the white juvenile crime arrests and that 35.8% of black children live in households headed by a single parent.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	426108	7623	0	2008
Percent in household headed by single parent	13.2	0.1	0.0	2008
Percent in TANF (Grant) families	0.0	0.0	4.4	2009
Number enrolled in Medicaid	0	0	169387	2009
Number enrolled in SCHIP	0	0	37874	2009
Number living in foster home care	5378	95	178	2009
Number enrolled in food stamp program	0	0	116866	2009
Number enrolled in WIC	45056	1288	0	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	2301.0	2008
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	2.8	2009

Notes - 2011
2008 Vital Statistics

2000 Census - male, female head of household with children under 18 divided by total family households

Not broken down by ethnicity

Not broken down by ethnicity

Ethnicity not reported

AFCARS report

Narrative:
Only 1.8% of the children living in WV are reported as Hispanic or Latino ethnicity.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**
Living in metropolitan areas	86746
Living in urban areas	199516

Living in rural areas	234214
Living in frontier areas	0
Total - all children 0 through 19	433730

Notes - 2011
Based upon 2% of 0-19 population

Based upon 46% of 0-19 population

Based upon 54% of 0-19 population

No designated frontier lands in WV

Narrative:
The second most rural state in the nation, 20 of West Virginia's 55 counties are 100% rural according to the Census Bureau definition, with an additional 14 designated as 75% rural. Geographically, the region is characterized as having a rolling topography with rugged ridges and hilltops reaching upwards of 4,000 feet with remote valleys in between. The valleys often feel isolated and separated from the urbanized areas. It is this isolated feeling, ingrained in the landscape that has contributed to the strong sense of independence and family among Applalachians. For as much beauty as the geography brings, it can also be treacherous and impassable, causing a major barrier in accessing healthcare.

Culturally, Appalachians have core values and beliefs such as individualism and self-reliance. These same core values, which breed strong ties to family and tradition, also reflect detrimental health behaviors, the effects of conservative religion on medical care use, and feelings of alienation from national society.

Primary care centers are health care organizations, founded and operated by rural communities in West Virginia. They are funded, in part, by State and Federal grants administered by the Division of Primary Care. These grants help the clinics offer more services and better healthcare for their patients, regardless of the patient's ability to pay. Currently, in WV, there are 34 primary care organizations. Most, but not all, provide more than one clinical site. These primary care centers also house 17 Black Lung clinic sites and operate 36 School-Based Health Centers. This system of healthcare is constantly endeavoring to grow in accessibility and variety of services provided to engage West Virginian's in healthcare.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	1814468.0
Percent Below: 50% of poverty	18.0
100% of poverty	22.0
200% of poverty	60.0

Notes - 2011

Narrative:

Areas of critical poverty in West Virginia occur in both the most heavily populated areas of the state, and the more rural areas of the state. In more rural areas it can be much more difficult to access basic utilities such as electricity, water, and a sanitary sewage system than it is in urban areas. Also, due to poor road maintenance, long distances, or lack of reliable transportation, it can be much more difficult to reach a school or hospital in some rural areas. In the major cities such as Huntington or Morgantown, however, the higher poverty rates can be linked to a different set of reasons. In heavily populated urban areas, people are completely reliant on the market for all of their most basic needs. These needs include things like food, shelter, utilities, education, and health care. Most people living in poverty do work one or more jobs. However, if the cost of these basic needs goes up at a faster rate than the minimum wage, then the working poor living in these highly populated urban areas suffer.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	433731.0
Percent Below: 50% of poverty	15.0
100% of poverty	20.0
200% of poverty	65.0

Notes - 2011

Narrative:
Sixty-five percent of WV's residents ages 0-19 are living at 200% below the Federal Povery Level. Even so, because of the State's efforts to increase eligibility for CHIP up to 300 percent of the FPL by 2010, almost all children are insured in WV. The high rate of poverty does not seem to affect parents positive perceptions of their child's medical status.

F. Other Program Activities

The Office of Maternal and Child Health, since the 1980's, has contracted for the provision of direct health care. These contractual relationships include private sector physicians, university-medical school partners, hospitals, community health centers, and local health departments. All services are formally contracted with established performance standards portrayed in the written provider-OMCFH agreement. The exception to this format is Children with Special Health Care Needs, which was, until the late 1980's, administered by the former Human Services arm of the now Department of Health and Human Resources organization. This unit has maintained its direct service responsibility because of the scarcity of pediatric and pediatric sub-specialty providers in certain geographical areas of the state. The Program receives referrals from multiple sources. However, as the state has developed and improved population-based surveillance systems, more and more youngsters have been referred, as a result of the birth defect registry, birth score, blood lead testing, newborn hearing screening and metabolic screening. It is also important to note that the state's universal risk scoring of infants, called Birth Score, was modified several years ago to assure the identification of infants with or at risk of developmental delay. These children are referred to the OMCFH administered Birth to Three Program/Part C IDEA. In

addition, MCFH administers EPSDT, for children not enrolled in an HMO, again with direct care through community provider partnerships, but we do have access to information on each child, enabling us to identify youngsters with chronic or disabling conditions for referral to CSHCN. The primary care physicians are encouraged to refer children to CSHCN, and are routinely visited by pediatric field staff who serve as technical resources to the medical community.

All children assessed by CSHCN receive evaluation and care management services to facilitate access to additional services. All children enrolled in CSHCN, Birth to Three (Part C IDEA), or perinatal RFTS program receive case management and care coordination. Children participating in the Children with Special Health Care Needs Program access Medicaid, at a rate of 98%. This high percentage is attributed to CSHCN commitment to assist families with SSI applications, the expedited SSA/Disability Determination process, and our attention to obtaining health care financing for this targeted group.

The Office supports the Birth Score Project and Genetics Program administered by West Virginia University, Department of Pediatrics. The support for these programs are at the heart of building capacity for the system of care by providing preconceptual counseling; assessment and support for persons with congenital anomalies and operating a population-wide surveillance system designed to identify infants at possible risk of post-neonatal death (birth score, which includes newborn hearing screening).

Primary preventive health care for the state's children has been historically administered by OMCFH through provider contracts for EPSDT. Because Medicaid mandated enrollment of clients into HMOs, the WV EPSDT Program called HealthCheck is serving fewer and fewer clients.

OMCFH has well used toll-free lines. All calls, unless client refuses, are followed up by letter. OMCFH also maintain resource information on a variety of topics enabling us to respond to specific concerns. OMCFH program information is also available via Web access with multiple links to access informational guidance on a variety of topics.

Care management and care coordination is provided through established systems, with program specific protocols for each targeted population. In RFTS, social workers and registered nurses involve parents in discussion of family planning, and assist clients who are economically disadvantaged in accessing health care. OMCFH's cadre of community-based family outreach workers (FOW's) encourage families to participate in preventive, primary health care for their children through EPSDT.

Cervical cancer is one of the leading causes of cancer-related death among West Virginia women aged 25-44 years. The 2006 age-adjusted invasive cervical cancer incidence rate was 8.4 per 100,000. The opportunity to provide cervical cancer screening through the WVBCCSP is part of the effort to improve the quality of life for West Virginians. Women who meet certain clinical guidelines may also be eligible to receive a human papillomavirus (HPV) test through the WVBCCSP. This data is monitored through the WVBCCSP's surveillance system. Women diagnosed with invasive cervical cancer can also receive case management services and a Medicaid card through a partnership with the Office of Maternal, Child, and Family Health and the West Virginia Bureau for Medical Services if they are medically indigent.

Hearing is important to child development. Early identification of hearing defects is addressed three ways in West Virginia:
1.The newborn hearing screening efforts that occur at time of birth, see early references elsewhere in grant submission;
2.EPSDT screenings of all children eligible for Medicaid; and
3.Universal screening across all payors using the EPSDT protocol, for children entering kindergarten (ages 3, 4, 5 and 6).

Infants identified with hearing loss are tracked and if hearing amplification and treatment is required, the CSHCN Program works with the child's insurance to secure treatment including hearing aids. Because child development can be severely impaired, young infants/toddlers and families are offered a referral to Ski*Hi which is a free comprehensive home-based pre-school/parent education program for deaf and hard of hearing children ages birth to five years and their families. The goal of Ski*Hi is to use the child's natural environment to improve and increase the child's language and communication skills.

To prevent duplication, Ski*Hi and West Virginia Birth to Three (Part C/IDEA) collaborate to develop intensive educational and developmental programs for children birth through age 2. Because Ski*Hi eligibility goes beyond age 2, they can serve all those who age out of BTT.

Ski*Hi parent advisors work with the parents of children who are deaf or hard of hearing to connect families to resources, including the WV Association for the Deaf. The Association offers members and non-members opportunity for socialization as well as problem solving discussions. To make the Association more accessible, Town Hall Meetings are scheduled throughout WV.

G. Technical Assistance

West Virginia needs technical assistance to improve capacity to address ethnic disparities and cultural competence. West Virginia is limited in addressing ethnic disparities and cultural competence due to the small number of minorities in the state's population.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	6493886	6432506	6412094		6432506	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	13518585	11774042	16845469		13300796	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	36246030	0	0		0	
6. Program Income *(Line6, Form 2)*	0	12153535	14000000		14000000	
7. Subtotal	56258501	30360083	37257563		33733302	
8. Other Federal Funds *(Line10, Form 2)*	10114465	16504838	15493727		16691340	
9. Total *(Line11, Form 2)*	66372966	46864921	52751290		50424642	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	4152159	1706133	1847089		1636704	
b. Infants < 1 year old	1016310	1684687	3634359		2540936	
c. Children 1 to 22 years old	3844537	2184705	2254379		2246378	
d. Children with	34606123	20292786	23089295		22306320	

Special Healthcare Needs						
e. Others	11259914	3583501	5407380		4156951	
f. Administration	1379458	908271	1025061		846013	
g. SUBTOTAL	56258501	30360083	37257563		33733302	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		94644		100000	
c. CISS	0		0		0	
d. Abstinence Education	289389		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	5116300		4357976		4376056	
j. Education	2138714		2135315		4533609	
k. Other						
Other	0		0		6935675	
WiseWoman	0		0		746000	
Comm Based Integr Sy	0		105000		0	
DHHS (HAPI)	0		233415		0	
Family Planning	2169564		2359564		0	
Newborn Hearing	0		149747		0	
TANF	0		3750619		0	
Title XIX	0		2307447		0	
Comm Based Intg Sys	146033		0		0	
Newborn Hearing Scre	159821		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	33807647	2090073	3240512		1948752	
II. Enabling Services	8029100	20821681	22255683		22469349	
III. Population-Based Services	3063275	4327832	8126592		6096037	
IV. Infrastructure Building Services	11358479	3120497	3634776		3219164	
V. Federal-State Title V Block Grant Partnership Total	56258501	30360083	37257563		33733302	

A. Expenditures

Please reference notes contained with forms 3, 4 and 5 for a dicussion of budgeted estimates and actual expenditures.

B. Budget

The Office of Maternal, Child and Family Health has done a good job of leveraging resources. The Block Grant Title V, serves as the foundation but the Office also administers Title X Family Planning; Title XV Breast and Cervical Cancer Screening Program; Part C/IDEA; Childhood Lead Prevention Program, CDC funded; EPSDT, funded by Title XIX; Children with Special Health Care Needs, funded by Title XIX and Title V; and PRAMS, funded by CDC. All of these funding streams augment what is purchased with Title V monies. Like many states across the country, Title V has moved away from the sole focus of purchasing or providing individual health services and has placed most of our attention and fiscal resources on developing a system of care. For example, because the state had high incidences of neural tube defect and other congenital anomalies, the OMCFH approached the WVU School of Medicine to develop satellite clinics providing genetics counseling and screening. Although the medical expertise came from the WVU School of Medicine, the funding to make these services more accessible throughout the state came from Title V. These clinics serve everyone, not just persons who have government sponsored health care.

Because of the low median income for a family, the need for services has been great but resources have been limited. The State Legislature routinely supports Maternal, Child and Family Health, but over the years this commitment has not kept pace with the demand for services and escalating cost. This is largely attributable to the fact that as Medicaid expansions occurred and the CHIP program was introduced, there was an assumption by members of the State Legislature that Maternal, Child and Family Health would not need as many resources. OMCFH has attempted to educate the Legislature, explaining to them that while these alternate health financing strategies have come into being, the MCH monies are needed to improve the quality of services rendered and improve the availability of care. Like states across the country, WV does not have enough money to fund all the many things that our citizens need. For example, several years ago newborn hearing screening legislation was passed but there was no accompanying state appropriation. What was obvious was that, while there was a commitment to identify children who needed intervention, there was no consideration given to the fact that there has to be a mechanism for identifying the children, tracking the children, and making sure the intervention occurred, all of which costs money. OMCFH staff argued this to no avail, OMCFH was very pleased to be a recipient of the Title V monies to support this project. It is true that Medicaid and some insurers would offset the cost of the newborn hearing screening services, but there was no way to individually bill and recover monies necessary for the population-based tracking and surveillance that was necessary; no insurances or Medicaid pay for this activity.

In order to be good stewards of the system, the OMCFH provides leadership for much of the health care services provided in the state. Medicaid, CHIP and others are purchasers, but the OMCFH and its staff recruit the clinicians, establish the care protocols, monitor provider behavior, and offer skill building opportunities, all using the resources identified above to improve WV's health care system.

The WV OMCFH administers EPSDT on behalf of Medicaid, for children not enrolled in an HMO, and has done so for approximately 30 years. The Medicaid Bureau supports the Program by paying for individual health services that the children access and administrative support for salaries of the MCFH team administering EPSDT. The OMCFH develops, distributes, and purchases anticipatory guidance which is used by the participating providers. OMCFH also is responsible for bringing together members of the medical community to provide guidance as it relates to child health, not just EPSDT, but Newborn Hearing, Children with Special Health Care Needs, Birth Defects, Lead, etc. OMCFH uses many of the programs cited to identify children who are ultimately referrred to CSHCN. The CSHCN Program, financed under Medicaid and Title V, not only serves children who have diagnosed chronic and debilitating conditions but arranges assessment for children referred by their primary care/medical home. All of these efforts are commitments to primary and preventive care of the state's children and ultimately have a tie-in to

CSHCN when indicated.

Using the statutory authority under Title V that allowed for cost based reimbursement for Medicaid beneficiaries and the authority invested in Title V to be responsible for all populations, OMCFH embarked upon an ambitous redesign plan for our Birth to Three/Part C system. This redesign has allowed the State of WV to implement a system change that is more in keeping with tenents of Part C and to obtain financing necessary to support the system. This system is designed to serve children who are developmentally delayed or at risk of developmental delay, but the many programs administered by the Office serve as a referral conduit. Referral sources include the Birth Score screening that is completed on every baby born in WV to screen for developmental delay or identify those at risk of post neonatal death, the Birth Defects Surveillance System, Newborn Metabolic and Newborn Hearing Screening programs, and of course EPSDT. This system change has been in the process for about four years and has resulted in families having an opportunity to select a provider of service, improved financing for the system, and assurance that families are served by appropriately credentialed personnel. OMCFH has used Title V connections and fiscal resources to secure support from the medical community including developing physician training programs, offering skill building around the early detection of developmental delay, and to champion messages to their colleagues that the early identification of children who are at risk are important to all.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.